





# MENTAL HYGIENE

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THELMA V. OWEN, M.D.

M. G. STEMMERMAN, M.D.

## An experiment in public education

It is generally acknowledged that one of the chief obstacles preventing early treatment and complete rehabilitation of patients with emotional disorders is the stigma attached to the words *mental illness*. One of the reasons for this stigma will be erased when the recovered mental patient is willing to discuss his illness as freely as the surgical patient discusses his operation. Efforts by isolated patients, such as Clifford Beers, Jim Piersall and others, have probably been more helpful than the combined words of all professional workers. Yet it is difficult for the average citizen to identify himself with a public figure such as Mr. Piersall—sick or well. Recent public addresses by patients at Ancora State Hospital in New Jersey may very well be more convincing. It is the purpose of this report to describe an experiment which has had considerable influence on attitudes toward mental illness in our community.

The Owen Clinic Institute is a small

private hospital with in-patient and out-patient facilities. In order to provide the best possible psychiatric care for the average middle-class family, fees are kept at a minimum and whenever necessary installment payment plans are arranged. Approximately 50% of admissions have previously had state hospital care. Most patients are housewives, clerical workers or teachers. During the last weeks of hospitalization patients are encouraged to attend mental health, community welfare and other civic meetings in town, as well as concerts and lectures.

Over the years many ex-patients found mutual support following their hospital experience in visiting each other. Finally, they resolved to form a club in order to be helpful to other newly discharged patients,

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Dr. Owen is psychiatric director and Dr. Stemmermann medical director of the Owen Clinic Institute in Huntington, W. Va.

as well as to aid families of newly admitted patients. In January 1950 the by-laws adopted included several types of membership. For full membership—source of officers and committee chairmen—a member must have been a mental patient judged "recovered" by the psychiatric director of the institute or a close relative of the same patient. (Consultation service to decide "recovery" status is the psychiatrist's only connection with the club.) Full members, both recovered patient and relative, must be willing to identify themselves by full names in connection with any of the club's public service projects or publicity. Since 1952 every full member has appeared in the role of an ex-mental patient or family member on at least one radio program. Many have also appeared on television. Several are mental health chairmen of their local and county Parent-Teacher Associations.

In the spring of 1956 the county mental health association held a public meeting with a panel of professional people (social worker, minister, physician) who discussed mental health generally and the community's need for a mental health clinic. A member of the ex-patient's club was asked to serve on the panel to speak for the average citizen and his mental health problems. Discussion by all panel members was interesting and informative but the ex-patient stole the show with the story of her illness, hospitalization and readjustment in the community. Her statements, forthright and knowledgeable, stimulated a prolonged question and answer period.

Following the meeting an officer of the mental health association suggested that if one ex-patient contributed so much to a panel, a complete panel of ex-patients might be even more influential. The club agreed with the suggestion and prepared to send a panel to any group requesting a mental health program. A panel usually consists

of two ex-patients, each of whom has had a different type of illness, and a relative to describe the impact of the illness on the family unit. The moderator who introduces the panel speakers is a lay member of the institute's board of directors or the local mental health association board. During the last year 12 panel programs have been given to church circles, women's clubs, men's service clubs and county mental health associations.

The following quotations summarize the introductory remarks of a few of the panelists. Speakers do not read their statement but have put their substance in writing for this report. A question period follows the prepared remarks. Unless addressed to a specific speaker the moderator calls on whichever panelist he believes can best answer each question. Full names are used by the panels, in accord with the club policy.

One former patient, 36 years of age, was never gainfully employed until after discharge four years ago. Now she is working as a hospital housekeeper and is taking correspondence school courses. She was hospitalized 8 months for schizophrenia. She tells audiences:

"September 1952, a red-letter day in my life—I walked into a psychiatrist's office for the first time, referred by my family doctor. The psychiatrist was very kind. She verified what the medical doctor had told me—I was mentally ill and I would need weekly office consultations.

"During the next four months I visited her once each week, meanwhile trying to care for my three children and take part in community life. I planned to return to school in January 1953, but for financial reasons I could not return. This was the straw that broke the camel's back. I had a complete schizophrenic breakdown. I do



not remember all details of what I am now going to tell you.

"I had an appointment with Dr. Owen. I did not keep this appointment. She said I called and told her I was too sick to come. Later I went to a justice of the peace, a man I thought to be my friend, told him I was crazy, and asked him to take me to Owen Clinic, 100 miles away. He locked me in a cell, called the state police and they took me to the county jail. There I was locked in with drunks and prostitutes, crying, walking the floor, begging them to let me out and take me to Owen Clinic or call Dr. Owen, my psychiatrist. I was granted neither request.

"I was examined by medical doctors who were not qualified for this, declared insane by the court and committed to a state hospital. My first comment on entering the institution was, 'This is not a hospital; this is just another jail.'

"During the next two days I was given a few electric shock treatments but never saw a psychiatrist. I spent the time in my room alone in bed. Meanwhile all this time Dr. Owen had been trying to locate me. One day she walked into my room at the institution and said 'hello.' I looked at her and thought: 'This is not she; it's just another hallucination.' But it was true she had found me at last, her lost sheep. She came back next day, gathered me up and took me to the 'fold,' Owen Clinic.

"There I received adequate treatment along with the tender loving care that every mental patient needs."

Two other panelists, both 53 years of age, are husband and wife. She was a clerical worker before three months' hospitalization for depressive reaction. After discharge two years ago she returned to her old job. Her husband, a salesman, was engaged to be married to her at the onset of her illness

and was treated in the out-patient department while she was hospitalized.

The husband: "All of you good people listening to me will leave this meeting with the thought, 'That will never happen to me or mine.' This is a perfectly normal reaction and I hope it is true. I thought that way too. But it happened to me.

"I wonder where you should start talking about a subject that is distasteful and shrugged off by most. Should I tell of my experience? Yes, I have been a mental patient. With me it lasted about four months. A short time, true, but to me a lifetime. Fortunately I received early treatment, which made the illness shorter; we know the sooner treatment is started the sooner the patient recovers. My treatment was known as out-patient. I was working the whole time and later when I had recovered sufficiently to talk to others about my illness, to my surprise my behavior at the time was noticed by no one.

"Someone will ask 'How did it happen to you?' I wish I could answer. Unconsciously, meaningless events in everyday life became great factors and were world-shaking in their happening. 'When did it happen?' I can only answer that in retrospect. I remember one day leaving town and driving about fifty miles. I say I remember. Actually, my only memory of the trip is getting into my car and nothing else until I crashed into a bridge, fortunately with no serious consequences.

"You have gone over the edge and have no realization of it. You forsake your family, your friends and have no one to talk to because you are convinced no one will understand and no one will help.

"You are mentally ill. My best advice and the hardest to follow is this: tell somebody about your troubles and worries—someone you have trust in—someone close to you in your family—your minister

—your doctor. What do I do now when a problem arises I cannot cope with? I go to my psychiatrist. But get your troubles outside of you; put them on the table where they can be seen and picked apart. Most of the time you will find they are only shadows.

"Capable psychiatrists, new drugs and treatments all point to case after case of complete cure. Keep remembering this: never forget the one who is ill needs your love and understanding more than ever. I know because I have had the experience.

"And to you who are perhaps wondering if I have forgotten Someone we can always turn to, I say go to God. He will never turn His back and will always answer your prayers. I know how He helped me and I am convinced saved my life.

"God grant it never happens to you who listen; but remember none of us is immune to heart disease or cancer and mental illness can strike any of us."

The wife: "Have you ever had a gnawing anxiety that you couldn't put your finger on? Just anxious for no apparent cause? Have you ever lain awake at night thinking you heard music? The same tune over and over and over? Or the voices of people in the apartment next to you or under you talking over and over and over in the same tone of voice, till you think you will have to get up and scream at them?

"I had a home, but I leased it and moved into an apartment uptown. This was before I realized how sick I was. I thought I would be happier uptown close to my work, with no yard to tend. My sons had married and moved away. That didn't bother me especially, because I had prepared myself for it, or thought I had. For a time I was fairly satisfied in the apartment and then the walls began to close in on me. I had no neighbors, as I had when I lived in my home. When I went in and closed the

door I was completely alone. No one to talk to—just four walls. I became so distraught that I was afraid to go to the fire escape to empty the garbage into the incinerator for fear I would jump off. Not afraid to die, for I felt that I would really welcome death to the life I was living—but afraid if I did jump I would only be crippled and become a burden to my family. I had aches and pains all over my body. The doctors I went to told me I had arthritis and they gave me shots and pills for that. I am not criticizing the doctors. They are all good men—but they just didn't go deep enough to find the real cause of my distress.

"Finally, I became so ill and tired that I went into a clinic for two weeks' rest, and at last I had found a doctor who understood. While there he gave me insulin shock treatment and I came home feeling well. But it didn't last. I was to report back to him at the end of a week. Within that week I had regressed to my old condition of anxiety and fear. The night before I was to report back to him, I put the man I loved out of my apartment with the sentence that he was not to come back—ever. I was beside myself.

"I went to the doctor the next day for my check-up and he saw immediately my condition. He said, 'My advice to you is to see Dr. Owen and to go into her clinic for treatment.' Like most people I was stunned. I said, 'But that is a mental hospital!' Even though I knew in my heart that I was mentally ill, I hesitated to admit it. His answer was, 'Either do what I say or you will end up in the state hospital against your will.' I knew if I ever went to the state hospital it would be against my will, because I had been a visitor there and I knew the conditions. I went back to my apartment and brooded over the thought of being a mental patient anywhere.



"Then I ran away. I called a friend I knew I could trust and she took me to her home and kept me until I saw Dr. Owen and made arrangements to enter the clinic. No one but this friend knew where I was for some time. This is not a plug for the Owen Clinic, but I found a home away from home. I was given thorazine to calm me down. I was kept busy every minute, attending classes in psychotherapy, English, occupational therapy, outside raking leaves and even sawing logs for the fireplace. I learned to live again without fear and without anxiety—and finally I married the man beside me and we are having a happy home life. True, I still have anxious, depressed moments at times, but my good Dr. Owen tells me this is to be expected. These times are becoming farther and farther apart. I am well and I am getting better."

A fourth panelist, 42 years of age, is the husband of another club member who was discharged after six months' hospitalization. He says to audiences:

"When my wife became ill, I found myself in a most difficult situation because I had no conception of mental illness. I saw the psychiatrist weekly in regard to my wife's progress but you do not grasp the reason or cause for mental illness in a short time.

"One of the difficulties I had was understanding the treatment used. As a rule, you think of sick people as needing rest and quiet, but for mentally sick people it is just the opposite. This was brought home to me when I found my wife hoeing in the garden, participating in all types of sports, taking courses in everything from handicrafts to current events.

"It is now 10 years since my wife was discharged. Prior to hospitalization she had never worked outside the home and in fact was too fearful to leave the house un-

escorted. She depended upon me for everything. This has all changed. It is the former mental patient who is now the stabilizing influence—the one our son and I depend upon. In addition, she works as secretary to the principal of our neighboring grade school. Formerly, doctors' bills kept us perpetually in debt. Now we own our home and next year we are sending our son to college.

"The mentally ill *can* get well. I've seen it happen."

Statistical evaluation of improvement in public attitudes because of the Owen Clinic Club and its panels is impossible. We know of two results, one discouraging, the other hopeful. It is frequently discouraging to club members to overhear or have it said directly: "But, of course, *you* were never very sick—like patients in the state hospital." It is hoped that the panelists will dispel this misconception.

The hopeful sign is the fact that with one exception no club member has been refused a job following discharge although they never hesitate to admit prior mental illness and usually give Dr. Owen's name as reference. The one exception is a girl who returned to her factory job, completed high school by correspondence courses and then applied for job training in a telephone company. The personnel manager, who knew her past history, hired her and after a probationary period approved her for full time employment. The medical staff, however, general practitioners working part-time, refused to approve her appointment because of "company policy." This ex-patient is now working as a secretary in an automobile agency.

This case may be an exception. If it is not, one may conclude that the Owen Clinic Club has been less successful in changing attitudes of the general practitioner than in influencing attitudes of the general public.

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ROBERT SOMMER, Ph.D.

# Visitors to mental hospitals

## A fertile field for research

The visiting of patients in mental hospitals by interested relatives and friends has received very little attention. Lidz, Hotchkiss and Greenblatt (3) comment that "so little has been done in this field that (we) cannot do more than raise questions or delineate areas for future investigation noted in the few exploratory studies." Far more has been written about community volunteers and visiting entertainers than about visits by the patient's own family and friends. It has been the writer's experience

that more hospitals have a coordinator of volunteer services than have a full-time person to meet and talk to relatives. Often this latter task is performed in perfunctory fashion by an impersonal figure at an information booth or hospital switchboard.

However, many relatives are not discouraged by long journeys to isolated hospitals, inadequate visiting rooms, or patients whose conditions remain unchanged over the years. Yet we know little about the types of patients who receive visitors and the effects of these visits. Occasionally a nurse will notice that a patient is more relaxed after a visit, or he will begin to speak about going home himself, but on the whole the visiting of patients is largely an unknown quantity as far as mental hospitals are concerned. Research is lacking. Many hospitals consider visiting hours as something that is expected of them and

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Dr. Sommer is research psychologist at the Saskatchewan Hospital, Weyburn, Canada. He writes: We are grateful to Miss Olga Koshman for collecting the data and checking the case files of the patients. Dr. Humphrey Osmond, superintendent of the Saskatchewan Hospital, provided the stimulus and encouragement for the study. This research was aided by grants from the Rockefeller Foundation and the Ottawa Department of Health and Welfare.



make no effort to increase their therapeutic potential, either for the patients or for the relatives.

Solomon (4) maintains that visitors to mental hospitals usually come away depressed and discouraged. However, in a recent study Sommer and others (5) showed that a *planned* program for visitors resulted in a marked improvement in attitudes towards the hospital and awakened a desire to do volunteer work for the hospital.

The purpose of this study is to investigate some of the characteristics of those patients who receive visitors. We hope to determine the relationship between receiving visitors and the patients' present age, age at first admission, length of hospitalization, sex, and distance of home residence from the hospital. We also hope to see if those patients who receive visitors show a higher rate of discharge than the patient population as a whole.

#### METHOD

The study was carried out at a 1,600-bed mental hospital. The hospital is within the city limits of a town of 8,000, although the surrounding countryside is primarily agricultural. The hospital is 75 miles from the nearest large city (100,000 inhabitants). Relatives usually drive to the hospital and many come in large family groups. They register at the information desk where a man notifies the patients' ward of their arrival.

From the register at the information desk a list was obtained of patients who had received visitors during the 3-week period from October 1 to October 21, 1956. A record of all visitors had been kept routinely by the clerk at the desk. The information he obtained included the visitor's name, present residence, relationship to the patient, and the patient's name. When all

duplications had been removed, this yielded a total of 191 patients who had received visitors during this period.<sup>1</sup>

To determine in what way this group differed from the patient population as a whole, it was also necessary to obtain a random sample of all patients in the hospital during this period. From the hospital roll of October 17, 1956 the name of every tenth patient was selected. As the hospital roll had kept the sexes on different lists, our sample was stratified according to sex but random according to all other factors. That is, the number of men and women in the comparison sample was in perfect proportion to the number in the total patient population.

This procedure yielded a total of 185 names. To provide samples of equal size, six more patients were randomly selected from the hospital roll and added to the comparison group. This resulted in two samples of 191 patients each: one containing patients who had received visitors and the second a random sample<sup>2</sup> of all patients in the hospital.

Each patient's file was consulted and the following information obtained: present age, age at first admission, total length of hospitalization,<sup>3</sup> sex, and home residence.

<sup>1</sup> The roster of visitors included only friends and relatives who came after the patient had been admitted. This excluded all relatives who accompanied the patient at the time of admission and all groups of volunteers who did not come to see specific patients. Also removed were the names of several patients who had died within a week after the visit of the relatives; these were cases where the physician had realized the patient was dying and had notified the relatives who came for a last visit.

<sup>2</sup> For the sake of simplicity, this group is referred to as a "random sample" although it is stratified according to sex.

<sup>3</sup> Computed by adding up all periods of hospitalization. If there were several admissions, the length of each period was summed and the total was used.

**TABLE 1**  
*Percentage of patients in each age range*

	PRESENT AGE OF PATIENTS							
	<i>Less than 20</i>	<i>20-30 *</i>	<i>30-40</i>	<i>40-50</i>	<i>50-60</i>	<i>60-70</i>	<i>70-80</i>	<i>Over 80</i>
Patients receiving visitors (N = 191)	2.1	6.8	15.7	22.0	13.6	14.7	17.3	7.9
Random sample (N = 191)	1.6	5.8	10.5	19.4	19.9	19.9	16.8	6.3

\* Literally this is 20.1-30, the next column 30.1-40, etc.

As this research was carried out approximately 14 months (December 1957) after the criterion date of October 1956, it was possible to see how many patients in each group had been discharged in the intervening period.

**PRESENT AGE**

Table 1 shows the percentage of patients in each age range for both the patients with visitors and the random sample of patients. Analysis of these data establishes that there is no relationship between the present age of the patient and whether or not he re-

ceives visitors. The proportion of young to old patients who received visitors parallels the proportions of young to old patients in the hospital population. A breakdown of the age groups by sex did not reveal any significant trends.

**AGE AT FIRST ADMISSION**

Table 2 shows the ages at first admission of the patients with visitors and of the random sample of patients. It shows a trend for the patients who received visitors to be somewhat older at first admission than the general run of patients in the hospital.

**TABLE 2**  
*Percentage of patients in each age range at time of first admission to hospital*

	AGE AT FIRST ADMISSION							
	<i>Less than 20</i>	<i>20-30</i>	<i>30-40</i>	<i>40-50</i>	<i>50-60</i>	<i>60-70</i>	<i>70-80</i>	<i>Over 80</i>
Patients receiving visitors (N = 191)	5.8	22.0	20.4	12.6	8.9	13.6	12.6	4.2
Random sample (N = 191)	12.6	26.7	24.1	14.1	5.8	8.4	4.7	3.7



TABLE 3

*Percentage of patients at varying lengths of hospitalization*

	LENGTH OF HOSPITALIZATION					
	<i>Less than 1 year</i>	<i>1-5 years</i>	<i>5-10 years</i>	<i>10-15 years</i>	<i>15-20 years</i>	<i>More than 20 years</i>
Patients receiving visitors (N = 191)	17.8	41.9	13.1	7.9	8.9	10.5
Random sample (N = 191)	2.1	22.5	13.1	9.9	13.6	38.7

When these data are divided at the median, the table shows that significantly more patients who received visitors were over 40 years old at first admission than would be expected on the basis of the proportions in the total patient population ( $X^2 = 8.00$ ,  $p < .01$ ).

The average age at first admission for the patients with visitors was 46.3 years while the average age at first admission for the random sample was 39.3 years.

#### LENGTH OF HOSPITALIZATION

Table 3 shows the length of hospitalization of the patients who received visitors and of the random sample of hospital patients. There is a striking difference between the groups. Patients who received visitors have been in the hospital significantly less time

than patients who did not receive visitors during the observation period. In fact, there is a direct relationship evident in this table between the length of hospitalization and the percentage of the group that received visitors.

The average length of hospitalization for the random sample of the hospital population was 16.6 years while the average length of hospitalization for the patients who received visitors was 7.4 years. This difference is highly significant ( $t = 8.83$ ,  $p < .01$ ).

It is surprising to find that there is no relationship between the present age of the patient and whether or not he received visitors, although there is this marked relationship between receiving visitors and length of hospitalization. This surprise would be based on the belief that there should be a

TABLE 4

*Length of hospitalization of patients in random sample at different age levels*

	PRESENT AGE						
	<i>Less than 30</i>	<i>30-40</i>	<i>40-50</i>	<i>50-60</i>	<i>60-70</i>	<i>70-80</i>	<i>Over 80</i>
Median years in hospital	4.0	10.0	18.0	22.0	23.5	14.0	5.5
Number of cases	14	20	37	38	38	32	12

TABLE 5

*Age at first admission of patients in random sample discharged within a 14-month period*

	AGE AT FIRST ADMISSION						
	<i>Less than 20</i>	<i>20-30</i>	<i>30-40</i>	<i>40-50</i>	<i>50-60</i>	<i>60-70</i>	<i>More than 70</i>
Patients (N = 21)	2	6	1	5	1	6	0

direct relationship between the present age of the patient and the length of hospitalization. However, this assumption is incorrect as there is definitely a curvilinear relationship between these variables. This is attributed to the fact that many of the geriatrics patients at the hospital are comparatively recent admissions. In fact, the oldest group of patients in the hospital has proportionally more patients in the hospital for less than five years than the patients who are between 30 and 40 or between 40 and 50 years old. The median length of hospitalization for patients in each age range in the random sample is shown in Table 4.

#### DISCHARGES IN INTERVENING PERIOD

As the criterion visiting period was October 1956 while the examining of the case records took place in December 1957, it was possible to see which of the patients had been discharged during the intervening 14 months. The results showed that 50 of the patients who had received visitors were discharged during this time while only 21 of the random sample had been discharged.<sup>4</sup>

Although it does not directly concern the matter of visiting, it is interesting to note some of the characteristics of the group of

21 patients of the random sample who were discharged in this period. Tables 5 and 6 show the length of hospitalization and the age at first admission of this group. If these figures are compared with those in Tables 1 and 3, we find that there is no relationship between age at first admission and whether or not the patient has been discharged in the 14-month period. However, there is a direct relationship between the length of hospitalization and whether or not the patient has been discharged during this period. Although only 25% of the random sample of hospital patients were in the hospital less than 5 years, 86% of the patients (in the random sample) who were discharged within the 14-month period were in the hospital 5 years or less. There were no relationships between discharge in this period and the present age and sex of the patient.

#### SEX OF PATIENT

The actual composition of the hospital patient population at the time of the study (October 1956) was 59% male and 41% female. However, of the patients who received visitors 44% were males and 56% were females. This is a statistically significant difference ( $X^2 = 8.20$ ,  $p < .01$ ) and shows that the female patients received proportionately more visitors than the male patients.

<sup>4</sup>Fifteen of the random sample and 13 of the patients with visitors had died during this period.



TABLE 6

*Length of hospitalization of patients in random sample discharged within a 14-month period*

	LESS THAN 1 YEAR	1-5 YEARS	5-10 YEARS	10-15 YEARS	15-20 YEARS	MORE THAN 20 YEARS
Patients (N = 21)	4	14	0	1	2	0

#### DISTANCE FROM THE HOSPITAL

Table 7 shows the percentages of the patients as classified by the distance that their home residences are from the hospital. One might expect that patients who had lived closer to the hospital would receive more visitors than those who had lived at a greater distance. This is not supported by these data. Patients who received visitors had lived proportionately the same distances from the hospital as the random sample of patients.

#### DISCUSSION

Of the variables examined in the study, the length of the patient's hospitalization is

most closely related to whether or not the patient has visitors. The longer the patient is in the hospital the less likely he is to have visitors. It is important to note that this is relatively independent of the patient's present age. This is further evidence for the disculturating effects of large mental hospitals. In other studies (6) we have shown the minimal level of interaction that occurs on mental hospital wards and the paucity of recreational activities. In a previous paper we compared our patients to people sitting in a waiting room for a train that never appears. This study shows that the longer the person has been waiting, the less likely he is to leave the room or have

TABLE 7

*Distance from hospital of patients' home residence*

Miles from hospital	PERCENTAGE OF PATIENTS	
	Patients with visitors	Random sample
0-50	11.6	9.4
51-100	38.7	32.2
101-150	18.8	25.1
151-200	9.4	8.8
201-250	13.3	8.2
251-300	5.5	14.0
301-350	2.2	1.8
Over 351	0.6	0.6

his vigil interrupted by a visit from friends or relatives.

We hope soon to be able to study time perception in long-stay patients. On the basis of some pilot research there is evidence that the patients' sense of time is grossly distorted when it comes to matters of years or decades. Some patients speak of the outside world in terms of the world they had known 30 years ago (2). A few express a desire to leave the hospital "because they are needed at home" when the home they had left several decades ago no longer exists.

Although there was a striking relationship between length of hospitalization and receiving visitors, we are not able to infer a causal relationship between the two variables. It seems logical that receiving visitors might awaken a desire to go home in a patient, or show him that he still has a home to return to, but there are still other possibilities. One might think of the large isolated mental hospital as a grossly dislocating social institution; the longer the patient is in the hospital the more de-socialized he becomes and the more likely his relatives are to consider him incapable of living outside again. In this case the relationship between visiting and length of hospitalization would be a by-product of the dislocating effects of the hospital, rather than a causal connection. However, we are able to state definitely that a marked relationship between these two variables *does* exist, and it will require some more specific research to establish the precise nature of the connection.

For example, we will need to know the *effects*, both immediate and over time, of visits to various types of patients by their relatives. At present we often assume that such visits are inherently beneficial to patients and relatives. Perhaps it is possible to learn if this is really so and to what extent the hospital administration could in-

crease the therapeutic value of the visits. Do we really know anything about the possibility of using selected relatives as volunteer workers? Greenblatt, York and Brown (1) mention that this has been tried at Boston Psychopathic Hospital but we do not know the outcome of this program and whether it could be extended to more isolated institutions with fewer staff members. It is imperative to know why some relatives will visit a patient regularly and others will never come to the hospital. How much of this is owing to negative stereotypes about the hospital? To a lack of knowledge about visiting hours? To a lack of encouragement from the hospital administration?

These are important questions and we hope to learn some of the answers by interviewing relatives who visit the hospital and also by sending a questionnaire to patients' relatives who never have visited the hospital.

## SUMMARY

The characteristics of patients who receive visitors and the effects of the visits are extremely fertile fields for research. In this study, the relationships were investigated between whether or not a patient received visitors during a 3-week criterion period and his present age, age at first admission, length of hospitalization, sex, distance of home residence from the hospital, and whether or not he was discharged within a 14-month period.

During a criterion period (October 1-21, 1956) the records of all patients who received visitors were examined and information on these factors was recorded. The same was done for a random sample of equal size from the total hospital population. The two samples were then compared to determine in what way the patients who



received visitors differed from the random sample of the total hospital population.

The results disclosed that there was no age difference in the two samples. However, the patients who received visitors tended to be slightly older at first admission than patients in the general hospital population. There was a marked relationship between length of hospitalization and whether or not the patient received visitors. The patients who had received visitors averaged 7.4 years in the hospital while the patients in the random sample averaged 16.6 years in the hospital. Female patients also received more visitors than would have been expected on the basis of the proportion of females in the total hospital population. The visiting was unrelated to the distance of the patient's home residence from the hospital. Of those patients who received visitors, 50 were discharged within 14 months after the criterion period, while 21 patients in the random sample were discharged. Whether or not the patients in the random sample were discharged was

highly related to the length of hospitalization, but unrelated to the present age of the patient.

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## Form and function

Caudill concludes that the present form of the psychiatric hospital has been largely determined by historical circumstances, and that psychiatric hospitals in the future may be structured very differently depending upon specific therapeutic goals. He suggests several ways in which psychiatric hospitals might be changed so as to become true therapeutic communities.—Excerpted with the permission of the Institute of Living (Hartford, Conn.) from a review of *The Psychiatric Hospital as a Small Society* by William Caudill (Cambridge, Harvard University Press, 1958) in the *Digest of Neurology and Psychiatry*, 26 (July 1958), 299.

## Socialization and sewing as the means to an end

Using occupational therapy sewing groups as a means to an end in group therapy is not new, but a project which is now underway at the Larned State Hospital has shown such excellent results that it is believed worthy of passing on to other institutions.

The coordinator of adjunctive therapies instigated the project. Not having enough psychiatrists or psychologists employed at the time to work on the project, the superintendent decided to utilize the coordinator as group therapist, an occupational therapist as sewing therapist and the industrial therapy head as observer. During the first two weeks in March 1957 the doctor in charge of the regressed ward of the hospital was contacted and asked to select seven or eight women who had been in the hospital

for some time, who had shown little improvement during their stay and who could possibly benefit by a long-range sewing program. Seven names were submitted and the group started work on March 15. The average length of stay in the hospital for the seven had been six and a half years. During this time most of them had had shock treatment and milieu therapy but very little progress had been noted on any of these patients.

Patient A, a 33-year-old housewife, was admitted to the hospital in 1955 and her illness diagnosed as schizophrenic reaction, chronic undifferentiated type with partial remission. This patient's father had been in a mental institution since 1938. She is the mother of four children and has shown very little progress since her admission to the hospital.

Patient B, a 44-year-old single woman

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Mr. Irwin is coordinator of adjunctive therapies at the Larned State Hospital in Kansas.



with a diagnosis of manic-depressive psychosis, was admitted to another institution in 1939 and after spending nine years in that hospital was transferred to the Larned hospital in 1948. She had spent 11 years of her life in mental institutions.

**Patient C**, a 32-year-old housewife with no children, had been diagnosed as having schizophrenic reaction, chronic undifferentiated type, and had been in the Larned State Hospital for almost three years.

**Patient D** was admitted in March 1956 and was given a diagnosis of schizophrenic reaction, paranoid type. This woman is the mother of four children and has had considerable difficulty in adjusting to her family and community during the last eight or nine years. She is 38 years of age and has shown little or no recovery since entering the hospital.

**Patient E** is a 47-year-old single woman with a record of having worked in telephone exchanges for 20 years prior to entering the hospital. She was admitted almost eight years ago and at the time of admission was listed as suicidal. She has one uncle who has been judged insane, another who has been listed as a religious fanatic, and several relatives who are said to be neurotic. Her diagnosis is schizophrenic reaction, paranoid type. She has hallucinated during her stay in the hospital and for the most part has been extremely hostile during her entire stay.

**Patient F** is a 56-year-old married woman with no children who was admitted to the hospital four and a half years ago with the crime of murder listed on her chart. Her diagnosis is manic-depressive, depressed type, with a borderline mental deficiency.

The last of the group of patients has been in the state hospital for 16 years and has spent about 25 years of her life in and out of hospitals. She is now 41. Her father died as a mental patient at the Larned State

Hospital. Her grandmother died in another state institution and the family has a long record of mental illness. She is classed as a psychopathic personality without psychosis.

Most of these patients have grown up in a neurotic atmosphere. Fathers, mothers, uncles, aunts and other members of the family have had mental illness and these patients have been raised in this atmosphere. Almost every one of these women has had a very real problem in relating both to her own family and to the community. A reading of the charts on each of the women shows that there has been an intrapersonal difficulty outside of the hospital which has forced them to be committed to this institution. These seven were selected with the idea that perhaps by working and talking together every day they would be able to solve a number of their own problems. Also, working with outside groups on the sewing projects and feeling that they are needed would provide them with a family tie which might help them to solve their difficulties.

After the list had been compiled the coordinator contacted the head of the welfare program for Pawnee County and asked for a list of needy families in Larned who could use clothing. The head of the agency gave three names, and after checking the three families one was selected to be "adopted" by the group of seven patients. This family consisted of a mother, a father who had been in a hospital for three months with a heart attack, and 7 children ranging in age from six months to 16 years.

At the initial meeting the coordinator, the occupational therapist and the observer explained the purpose of the group to the seven women patients. On the second day the group was taken to Larned to meet the family they had "adopted." The mother of the family talked to the patients, visited

with them at great length, and told them approximately what the family would need in the way of clothing for both the summer and also for school days in the fall. The group spent approximately an hour in the home of this family. During the next few days the occupational therapist went over plans with the group as to what type of clothing could be made for this family—dresses for both the girls and the mother, shirts for all the boys and the father, nightgowns and pajamas for both the boys and the girls, sunsuits for both boys and girls, bedding for the entire family, dolls for the girls, sunbonnets and many other items. About April 1 the group began meeting regularly an hour a day on Monday, Tuesday, Wednesday and Thursday and spent these hours in sewing for the "adopted" family. On Friday the coordinator and observer met with the group to discuss events that had come up during the week.

At first the patients were hesitant to speak out in group therapy. But the longer they worked with the therapist the better they became acquainted with each other and the more harmoniously they got along. During the Friday discussions they began more and more to relate their problems to the group and to help solve each other's difficulties. Psychiatry teaches that the nucleus of finding out about one's own problems is in discussing them with other people, and this soon came about at the Friday meetings. The women began to relate to the downtown family they had "adopted" and began investing of themselves in the group project.

Practically all of them had had a feeling of failure at the time they entered the hospital. But as the articles of clothing began taking shape they slowly began ridding themselves of this feeling of failure; they felt they were, for the first time in their lives, actually doing something worth while for

someone else. Most of them had the problem of getting along with others and this took some time to dispel, even working as a group. There was a great deal of friction among them during the first two months of the project. Only one sewing machine was available for the entire group and a great number of bitter arguments arose over who was going to use the machine. Such things as the use of scissors, tables for laying out patterns, the use of patterns and other items also brought about rather heated discussions. As time went on and the group met daily, many of these problems dissolved and now the women may be found any day in complete harmony, with no arguments as to the use of the machine or materials. Many times the patients now work together with one holding the pattern while the other one marks, or one may be found cutting materials for another patient who is sewing on the machine. It was soon found that the one hour given to sewing classes was not long enough and the periods have been lengthened to an hour and a half daily. During the last six weeks there has been only one argument between patients, this involving a pair of scissors, and the patients themselves solved it quickly with no help from the therapist. During the entire time the occupational therapist in charge has been strictly a spectator giving only a word of advice here and there to the patients. In this way the patients have begun to depend on their own judgment and reasoning and are thus solving their own problems. The Friday discussions, which at first brought out only the gripes against such personnel as doctors, psychologists and other members of the staff, have now arrived at a point where actual problems of the patients are brought out by the patients themselves and are being solved by group discussion.

By June the group felt that they had enough clothing made to take into town



and give to the family so that they could get the use of it during the summer months. Playsuits and other items for summer wear were taken in and the group met again with the lady of the house and the children at which time she served punch and cookies to the patients. Two of the children modeled their garments and this did a great deal to bring back the home life situation to those patients who had had children before entering the hospital. The group came back to the hospital more determined than ever to make more clothing for the children to use in school. On September 5 they again made a trip to Larned to take clothing.

A check at this time revealed between 55 and 60 completed articles of clothing had been made by this group of seven so-called "regressed" patients. Most of the clothing made would stand inspection with manufactured articles. The total cost of material and patterns up to this point was \$22.85.

For the most part the patients by this time had a feeling that they were definitely needed by the community and that they were for the first time contributing something that was extremely helpful to other people. This in itself did a great deal to rid them of the feeling of failure they have had for the past many years. The coordinator reinforced their feeling of being needed by laying out several possibilities for service to other patients. The women themselves decided to make stoles and bootees for the women in the geriatric section. (All of these geriatrics patients are over 65 and even though the buildings are well heated they like to have stoles to wear about their shoulders and to wear the booties in the day hall while watching television or reading.) The new project has gone so well since it was started in September that not only are the members of our group making stoles and bootees for the

geriatric section but they have also taken on three more female wards and hope to have between 90 and 100 complete outfits ready by Christmas to give to these wards. Since the hospital has no funds available for such a project, other than for use as occupational therapy materials, which do not include flannel for the stoles or bootees, it became necessary to find "good fathers" to supply funds. A local store was having a sale on flannel at less than half price. The leader of the group contacted five of the civic organizations in Larned, getting checks ranging from \$5 to \$10 from each one, and with this money bought enough material to complete the entire project.

From March 15 to November 15 three of the original group of seven women have left the hospital and four new members have been added. Of the four remaining in the group who were in at the start of the project, two are now definitely planning to leave the hospital. Because of court charges another cannot be released outright but her case is in the planning stage for boarding home placement. Only one of the original seven has shown little or no progress since the group was formed.

The socializing among the patients has produced tremendous strides in progress among at least six of the original group and the discussions on Friday are making the patients aware of their own problems and of the fact that most of these can be worked out by themselves. Patient A, after being in group therapy for four months, was released on July 29 for a trial visit and is now making a satisfactory recovery at home. Patient B has recovered enough since joining the group that she has now been transferred to a hospital in her home town where she can spend a considerable amount of time with her family. Patient C worked with the group for eight months

and has now returned to her husband for a trial visit and is at the present time making satisfactory progress on the outside. Patient D is now at a stage where it is felt she can be released from the hospital but she cannot return to her home environment and other members of the family are unable to help her at the present time; our social service department is now making plans to find her a job in a town close by and she should be released by the time of the publication of this article. Patient E has reached a point at the present time, through group activity and socialization in the sewing project, where she is planning to take at least a part-time job on the outside and continue her stay and group activities in the hospital until she is capable of functioning full-time on the outside. Patient F was the slowest of the group to take part in the activities but at the present time she is functioning extremely well; if the charges against her can be dropped or if she can be paroled, she is planning to go to a boarding home where it is felt she will

function extremely well. Patient G is the only one of the group who has shown little or no progress since becoming a part of the group. The aides and attendants on the section say that the sewing project has definitely reduced her hostility but aside from this she has made little progress. The diagnosis is sociopathic personality, and it is a well-known fact that very little can be accomplished psychiatrically with patients with this diagnosis.

This group project has been so outstanding that plans are now being made to start another group similar to this, perhaps with patients who are not in quite such a regressed state and who have not had so long a stay in the hospital. If this plan is completed, it will mean that possibly 16 women will be receiving help instead of the original seven which formed the first group. Since the work of this group has been so outstanding it has been asked that in the budget for next year funds be set aside for material and other items for use by these groups to continue them throughout the entire year.



# A new hypothesis in infant adoptive placements

Since the beginning of agency infant adoptive placements, emphasis has always been on matching the child and the adoptive family. Indeed, one of the gratifications of the adoptive worker has been in the neatness of this matching. Did the infant look like his adoptive parents? Fine! Did he appear to resemble them in his "infant personality"? Even better! And what about IQ? Did the baby's parents as well as the adoptive parents go to college? Delightful! Or even if both just had high school, or grade school, all was well as long as they matched.

From time to time there have been murmurs of discontent with this hypothesis of matching. Adoptive parents have protested as they waited for this chosen child, that agencies were being too fussy. A social worker having observed the emergence of

a good student from "poor heredity" questioned the limitation of this heredity if contra-influences were sufficiently powerful.

Sometimes it appeared that these influences didn't even have to be very strong. Love, security and meeting their basic physical needs, for example, often wrought near-miracles in the development of children in temporary custody of an agency. Suddenly a child works through adolescent inertia and becomes a new person in and out of the classroom. A child diagnosed as retarded finds security and love and growing self-confidence with the stimulus of small successes and develops into a normal, happy, productive child under foster home care.

Mrs. Latimer is supervisor of adoptions at the Children's Home of Cincinnati.

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Cumulatively, the social worker is constantly impressed with the possibilities of children properly stimulated by loving substitute parents. And this despite the most discouraging heredity.

The adoptive worker, however, is always haunted by the spectre of permanence. This is the whole emphasis in adoptive placements. We dare not take chances. A family's future happiness is at stake. Imbued as we are with the desire not to place a child where more will be expected goal-wise of him than he can do, and with the desire that adoptive parents never be disappointed, we hesitate to change policies and procedures which seemingly have withstood the test of time.

Nevertheless, as our agency did more adoptive placements of emotionally disturbed, difficult-to-place children, we *had* to change procedures. Obviously we do not "match" our emotionally disturbed child by placing him with emotionally disturbed parents. On the contrary, we deliberately search for a couple who, in the emotional and physical environment they provide, will counteract the "bad start" the child has had.

The ramifications of this practice are apparent. To return to infants, the problem was in the heredity as revealed in the social history. A considerable number of infants were considered non-adoptive unless our matching theory gave way to a different hypothesis.

A basic fact which had to be accepted was that purely scientific considerations could not be controlling in any new approach. Many of the appurtenances of pure research are lacking in the operation of any social agency. We believe, however, that philo-

sophic research can be productive. As has been said: "When we restrict our effort to science, the method of accuracy, we fail to move on to greater prophecy, the method of qualitative adequacy."<sup>1</sup>

A review of the literature reveals again the lack of research in adoptive work which has always been a handicap to agencies in projecting new hypotheses and/or in evaluating them once put in use.

In 1948, in the *Journal of Genetic Psychology* and in the same journal in 1949 are reports from the Iowa Child Welfare Research Station of the State University of Iowa which are pertinent to our hypothesis.

In the interest of brevity only the conclusions from these articles will be quoted. From the first, the author offers two statements:

- "Children of mothers with low intelligence or from fathers with low occupational status, or from a combination of both, placed in adoptive homes in infancy, attain a mental level which equals or exceeds that of the population as a whole."
- "The frequency with which cases showing mental retardation appear is no greater than might be expected from a random sampling of the population as a whole, and the frequency with which cases having superior intelligence appear is somewhat greater than might be expected from a random sampling."

From the second study, the conclusions from the material are as follows:

- "The above-average mental development of the children adopted in infancy has been maintained to early adolescence."
- "The educational or occupational data available for foster or natural parents in the typical social history record are not sufficient to predict the course of mental development of the children. Other fac-

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<sup>1</sup> R. B. Raup, "On Making Research Significant and Vital," *Advanced School Digest*, 6(Oct.-Nov. 1940), 1-11.



tors, primarily emotional and personal and probably located in the foster home, appear to have more significant influence in determining the mental growth of the children in this group."

● "The intellectual level of the children has remained consistently higher than would have been predicted from the intellectual, educational or socio-economic level of the true parents and is equal to or surpasses the mental level of own children in environments similar to those which have been provided by the foster parents."

"The implications for placing agencies justify a policy of early placement in adoptive homes offering emotional warmth and security in an above-average educational and social setting."

At one stage social workers were greatly influenced in making infant placements by the theory of developmentalism. We were impressed with the use of growth gradients in evaluating a child's potential. We often lost sight of the fact that these are neither inflexible nor definitive.

Gesell and Ilg say "... it would be sadly gratuitous to infer that adult ways of life are due to the imperfections of children. Sound inheritance greatly reduces these imperfections and wise management brings the others under control."<sup>2</sup>

Inheritance is important in prognosticating. But inheritance is frequently evaluated without norms or standards and without objectivity. Anyone looking at the "inheritance" of Lincoln or Edison could hardly have predicted their remarkable futures. Sir Frederick Banting, brilliant pioneer in research on diabetes and cancer was born on a frugal farm in Allison, Ontario, Canada.<sup>3</sup> William Osler, one of the great founders of modern medicine, was born in a family of nine at Bonhead on the edge of the wilderness in what was Upper

Canada; his mother was herself an adopted child and his father was a sailor turned clergyman.<sup>4</sup>

*Query:* Had these men come to an adoption agency as newborn babies, what level home, based on social history and heredity, would we have chosen?

The answer is fairly obvious: We would not have chosen a so-called superior home. Yet somewhere and somehow these individuals, through interpersonal relationships and perhaps a "plus" to which we will refer in more detail later, far surpassed their origins.

It is our belief that we cannot predetermine by a child's family background or by his growth gradients precisely what type of home is best suited to him. Our agency has developed a tentative hypothesis: The limitations of heredity are essentially limitations only to the degree that they are not overcome by appropriate emotional, intellectual and social stimulation and satisfaction.

We have operated gingerly under this hypothesis. With the very few cases involved we have tried to examine objectively the results of practicing within this hypothesis. Risk-taking has been held to a minimum and the danger of damage to our child through possible overplacement is controlled by the adoptive family, who can accept the child at whatever level his potential may finally be established.

The material which follows is essentially a preliminary report. It represents one point of view—probably a controversial one. Some readers will reject all, others

<sup>2</sup> Arnold Gesell and Frances L. Ilg, *Child Development* (New York, Harper & Brothers, 1949), 453.

<sup>3</sup> Lloyd Stevenson, *Sir Frederick Banting*, 2nd ed. (Springfield, Ill., Charles C Thomas, 1947).

<sup>4</sup> Harvey Cushing, *Life of Sir William Osler*, vol. 1 (New York, Oxford University Press, 1940).

disagree in part. Some will read skeptically, and this we welcome. (As Santayana says, "Skepticism is the chastity of the intellect—not to be surrendered too easily to the first comer.") Let us remember, though, that no procedure in any profession can be backed by a 100% guarantee. No profession can advance its technique and its service to its clients without thoughtful re-evaluation of policies and procedures and careful experimentation and research.

Adoption workers are familiar with the difficulties in the exchange of information. Perhaps another adoption agency is experimenting in this way, but since we have no knowledge of this our findings are arrived at independently.

No claim to statistical validation of findings is made. On the other hand, the workers involved in this experiment brought to it the knowledge gained through the placement in the last five years of 653 children—knowledge not specifically pertinent but basic to the ability to operate under our hypothesis.

Another observation which, though not unique, reinforced us is that many natural children are overplaced based on the natural endowments and achievements of the parents and many natural children are not properly placed, by agency standards, with their siblings either!

Our agency had two sets of adoptive parents who were "superior" families. That is, they had high cultural, educational, social and financial status in the community. Both sets were well educated: one was a professional man, the other a business man. Both families were outstanding in a far more important way to our agency: there would be no demands to achieve placed on an adopted child; there would be the love and stimulation of good parents, but no pre-determined goals.

With these two families we deliberately

"overplaced" by conventional matching procedures four children.

Family #1 had indicated no sex preference, and the first child placed with them was a 3-month-old girl. This baby's mother had been in numerous institutions and boarding homes until the age of 5, when she was placed for adoption. Her adoptive father was dead; her adoptive mother had no information on her background other than that she was illegitimate and on psychological tests was in the average range. The mother was suitably placed as a senior in high school at the time of conception. She had a poor relationship with her adoptive mother, and in her fantasies saw the alleged father of her child as a mother figure. She was an emotionally deprived person with marked oral needs, she had a strong super-ego and the consulting psychiatrist felt she was of average intelligence.

The alleged father, 40, was married and had children. He had limited education and an unimpressive work record.

There have been two psychological tests on the child. One at 2.8 months, the Cattell Infant Intelligence Scale, showed the child to be developing at a slightly accelerated rate of development in a good pre-adoptive study home. The second, at 3 years of age, indicated that the child was of far better than average intellectual development. Her verbal proficiency was excellent in terms of vocabulary and she was able to handle verbal abstract material in the manner of the average 4-year-old, but her memory span was more nearly average. Her perception of spatial relations was likewise not much better than average. She exhibited no difficulties in motor coordination insofar as observable. On the Binet she attained a mental age of 3.7 months and an IQ of 119, which would indicate that she is functioning on a superior intellectual



level. The psychologist said the second test results were not significantly deviant from those of the first test, though they seemed more nearly to reflect the child's potential.

On the Vineland Social Maturity Scale this child, in terms of self-help, social adaptivity and independence, scored at the 4.8-year level. Therefore, the psychologist felt the test results suggested she was exceptionally mature for her age.

The second baby, a boy, was the child of a 17-year-old girl who was failing two subjects in her junior year in high school when she withdrew because of pregnancy. Her background was not unusual; her father was dead; her mother had an unskilled job. A sibling had completed high school. When five years old and again at 11 the girl had had psychological tests which revealed average mental ability.

The alleged father of her child—about whom she was reticent to talk, almost to the point of denying sexual contact—was two years older than she. He was a high school graduate and in the service. She knew nothing else about his history. The girl apparently did considerable fantasizing about him as well as about her popularity with boys and girls. She was essentially an immature, rather withdrawn, young girl.

The baby had a great deal of physical difficulty which continued for several months after placement in the adoptive home, which occurred at six weeks of age.

He has had two psychological tests. The first at 7.8 months utilized the Cattell Infant Intelligence Scale and revealed that the child was developing at a slightly accelerated rate.

The second, at 21.6 months, found the child expressing both shyness and dependency upon the adoptive mother. Measured by the Vineland Scale he was in many respects more mature than most children his age. His verbal development seemed com-

parable to that of most 2-year-olds in that he combined words involving two ideas. He was as goal-oriented as most 2-year-olds, and as capable of retaining visual images after 10 seconds. His ability to identify three-dimensional objects was also at this level. His vocabulary was more nearly average insofar as was observable in the testing situation.

The test results indicated that this child was not functioning in any remarkable way different from that during the first test.

Family #2 had also indicated no sex preference and their first baby was a girl, placed at three months. The baby's mother, 28, was referred to us by the alleged father ten days before she was due to deliver. She had rejected pregnancy, had had no prenatal care, had no clothes for baby, etc. She had quit school at the 9th grade. None of her three siblings had finished high school. She had always had poor paying, unskilled jobs.

The alleged father, in his middle 40's, acted responsibly toward both the mother and the agency. He was a high school graduate with a stable work record on semi-skilled jobs. His numerous siblings also were stable on the job and were skilled craftsmen.

The baby was first tested at 2.2 months on the Cattell Infant Intelligence Scale and functioned at a slightly accelerated rate in a good pre-adoptive study home. The second test was at 3 years, 3 months. In such respects as cooperating with adult figures the child's behavior was comparable to that of a slightly older child. Her overall social adaptivity on the Vineland Social Maturity Scale was that of a child 3.4 years. A social quotient of 105 could be computed.

When seen by the psychologist the child exhibited an unusual amount of self-confidence and self-acceptance. She related re-

markably well to the examiner in an unfamiliar setting, and was able to accept her inability to perform certain tasks or problems to her own satisfaction.

The psychologist described her as a "merry little girl" who was, most of the time, responsive and eager to please. When she grew bored she became haphazard or gave joking, irrelevant responses. Her picture vocabulary was comparable to that of the average 5-year-old, according to Binet standards. Her dexterity was average but her perception of spatial relations was significantly better than average. She handled abstract data fairly well for a child her age, but experienced some difficulty in rapid shift of attention. Her ability to handle analogies was comparable to that of the average 4-year-old.

The psychologist pointed out that this child would certainly be ready to go to school at the appropriate age and it could be reasonably speculated that the quality of her school work would be above average. On the Binet she attained a mental age of 3 years, 8 months, and an IQ of 113. Her verbal skills suggested potentials for a slightly higher level of functioning.

The second child, a boy, was placed when he was 10 days old. He was born to a 19-year-old mother. At the age of 11 she had been removed by an out-of-state social agency from her parents' home, which had been considered unfit. She had left school at 15 when in the 9th grade. She had had some poor paying unskilled jobs. She apparently had average intelligence. Her inadequate knowledge of her parents provided little history and she had no recent contact with her siblings, whose intelligence could be presumed, she thought, to be average, though none had gone beyond the 9th grade.

The alleged father of her child, a high school graduate, was a garage mechanic; he

was 22. His younger siblings were properly placed in school.

This mother had strong maternal feelings—named her baby, etc.—but had no ambivalence regarding adoption.

Her baby was tested first at 6.0 months on the Cattell Infant Intelligence Scale. At that time his rate of mental development was accelerated. The second test was at 2 years of age. Results on the Vineland Scale suggested that the child was functioning at a superior level as to feeding habits, toileting, dressing and social responsibility. His proficiency and adaptivity in these areas were comparable to those of a child of 2.4 years. On the basis of this test a social quotient of 121 could be computed.

This child, too, related remarkably well to the examiner in an unfamiliar setting and accepted himself at the level where he was. He displayed excellent language facility for age. He was able to identify pictorially presented objects in the manner of the average 4-year-old. He was an active boy who as he worked voluntarily gave names to materials. When requested to build blocks in a certain way this 2-year-old not only accomplished the task but told the examiner that it was a bridge. He exhibited the motor coordination and fine finger dexterity of a child six months older. While he dealt with spatial relations in an appropriate fashion, he was not as precocious in this area as in others. His memory for verbal and non-verbal data was excellent. He had no difficulty in associating objects with their function.

Despite some fatigue and distractibility, this test performance indicated that the child's intellectual level of functioning was superior. His test performance yielded an IQ of 138 and a mental age of 2.9 years. The psychologist stated that apparently in his adoptive placement this boy had been able to realize his potentials.

ere we have, then, four children whose backgrounds were certainly "average" who with the love, acceptance, security and stimulation of "superior" adoptive parents are progressing socially, intellectually and apparently in that vague area of emotional stability at a rate more comparable to that of their adoptive than their natural parents.

One cannot prove nor possibly even allege that had we placed these children in a more "average" home their developmental history would have been different. Nevertheless, it seems safe to say that placement in homes above the level we would have chosen had we "matched" backgrounds has afforded these children the fuller development of their potentials. Isn't life going to be richer for them as a result of these placements?

Properly motivated, the "average"-hereditary child making full use of his endowment can surpass others better endowed but without proper stimulation. As Albert Einstein said, "... behind every achievement exists the motivation which is at the foundation of it and which in turn is strengthened and nourished by the accomplishment of the undertaking".<sup>5</sup>

So, too, H. E. Walter says, "... a hereditary character of any sort is not an entity which is handed down from one generation to another, but is rather a capacity in an organism to react in a certain definite way to the constellation of environmental factors in which it finds itself. It cannot be emphasized too often that inheritance does not depend alone upon the hereditary determiners in the germ plasm, but that the environment is indispensable. . . ."<sup>6</sup>

Later, Walter mentions the sleeping giant of possibility in everyone.<sup>7</sup>

Philosophically, too, one can reflect on the rights of the adoptable infant. Has he not the right to the very best home we can provide? Isn't that the reason for our care-

ful home studies? But how do we define "best"? The usual standards and values are important. Is that enough? If we accept our tentative hypothesis "The limitations of heredity are essentially limitations only to the degree they are not overcome by appropriate emotional, intellectual and social stimulation and satisfaction," our answer must be no.

Actually our hypothesis is not as heretical as first appears. Already, as good practice, we provide for our infants "better" homes in many ways than the natural parents could offer.

We think nothing, for example, of markedly raising the physical environment of our babies through adoptive placement. We know, too, that we provide many of today's babies, whose natural mothers are often teenagers, with older, more mature mothers. Comparative studies by our agency, in summary, of natural and adoptive parents indicate considerable differential in employment, education, income and stability.

It is primarily in the area of intellectual prognosis that we become timid. Any "experiment" in human relations is fraught with difficulty because of the emotions involved and because of the problem of evaluation. But how else can we learn?

We undertook another "experiment" with 17-month-old Tony. Here we were faced with conflicting and discouraging social, medical and psychological diagnoses. We had no family at the level we usually would have considered suitable and therefore a

<sup>5</sup> Albert Einstein, "Some Thoughts Concerning Education," *School and Society*, 44(1936), 590.

<sup>6</sup> H. E. Walter, *Genetics*, 4th ed. (New York, Macmillan Co., 1938), 7.

<sup>7</sup> *Op. cit.*, 337.



good match, who could meet this child's peculiar emotional situation.

Tony was born to a 23-year-old mother. She had attended school until her 16th year, when in the 10th grade. She was an unskilled worker of estimated average intelligence. There was nothing unusual in the full maternal history available to the agency. The educational achievement of her siblings was average for their age. Of the two of sufficient age to finish high school, one had done so.

The paternal history was also available in detail and was also "average." Tony's father, a high school graduate, had a good work record. His siblings were also high school graduates.

There was nothing unusual in the actual birth history. Labor lasted four hours with no foetal distress and Tony's reactions were spontaneous with no resuscitation needed.

Tony's mother, however, completely rejected this pregnancy and this child. She identified Tony with his now-hated father, made no plans for names, and always referred to the baby as "it." Both before and after Tony's birth she dreamed that there were many people around her and that she was always pushing the baby away from her. After Tony's birth, it was felt that the excessive bleeding and complaints of after-pains were psychogenic in origin.

Four days after birth, Tony was placed in a pre-adoptive study home and eight days later he was hospitalized for four days because of jaundice. From the beginning of the boarding home placement, however, the boarding mother and the social worker shared the feeling that this was a very unresponsive child who seemed to be developing slowly mentally.

By four months the boarding mother and the neighborhood general practitioner were thinking the baby was deaf and our pediatrician accepted tentatively that there

might be some degree of hearing loss. By the time Tony was a year old, however, a specialist had determined that the structure of the ear was normal.

In the meantime, when Tony was 2.9 months of age the agency psychologist found the baby's rate of mental development to be retarded and said he was not a good candidate for adoption. A re-test at 4.3 months resulted in the statement that his "rate of mental development is only slightly retarded and potentially low average." At 10.3 months the low-average rate was maintained with a potential of average.

As time passed, however, Tony was practically mute and such sounds as he made were guttural and not understandable. He did not respond normally to adults, children or infants. He did not appear frightened, but there was a "distance" and preoccupation about him that made him noticeably different. By now, too, he had developed strabismus.

The next step, of course, was psychiatric diagnosis. A reputable child psychiatrist saw Tony when he was 16½ months old. He felt Tony might give the impression of normalcy if one looked at him fleetingly. He said, however, that Tony's facial expression was quite blank, displaying very little vitality in expression. He showed no curiosity or interest in people or things. He made not one sound for 45 minutes and then a few meaningless ones. He showed little emotion and when given a cookie which he began to eat did not even cry when the cookie was taken abruptly from his hand.

His motor patterns were not considered good. He moved slowly and used his hands in a clumsy, immature way.

In summary, the psychiatrist felt there was nothing in Tony's total behavior really normal for his age. The psychiatrist classified him as a severely retarded child who

in his opinion would never qualify for legal adoption.

Faced with this total situation, the agency turned to a local physician with whom we had had previous contact through his adoption of a teen-age boy. All the above material was reviewed with this family in full detail and not accepted by them, after Tony visited their home, as final. He was placed on a "trial free home basis" with this family when he was 17 months old.

Almost immediately a remarkable change took place. With this exceptionally understanding, loving family Tony developed quickly. Within two weeks he was making understandable sounds for kitty, dog, man, dad and the equivalents of the other children's given names. In a few more weeks he related easily to visiting children and adults, ate at the table with family and visitors, and was acting in other ways in a "normal-average" way.

A children's eye specialist diagnosed his condition as a high degree of compound hypermetropia (farsightedness), astigmatism of both eyes and esophoria (inward deviation of an eye), and glasses were prescribed.

After nine months in this home Tony was seen by a neutral psychologist, the chief psychologist of a well-established psychiatric clinic. Her report, summarized, was: "Tony is an attractive and engaging child. Not large, he nevertheless looks healthy. His bespectacled appearance and his animation suggest a lively little gnome. In the family group the child responded rather naturally to the presence of a stranger, and was soon willing to show his toys to the psychologist and to talk about them to her. His adaptation to the test situation was good. He was not overly active, overly distractible, or difficult to direct. He responded with interest to the test materials and showed a good degree of persistence. Sometimes absorption in a particular object or activity

seemed to prevent him from responding maximally to other parts of the test—a behavior not unusual in young children.

"Tony's performance on the Revised Binet Scale, Form L, when scored very objectively, implies intelligence approximating the lower limits of the normal range. He uses his hands well and perseveres in motor activities. His speech is reasonably good, in that he combines words into rudimentary sentences; most, but not all of it, was intelligible. He has a reasonably good knowledge of common objects and their uses.

"The Vineland Social Maturity Scale, on which observational data was supplemented by information from the parents, suggests that in areas of self-help, locomotion, communication, etc., the child functions within the normal range.

"The results of the study, when viewed in consideration with the history, must certainly be considered encouraging. In any one test situation, a subject, particularly a young child, whose responses are frequently largely self-initiated, may not function at his optimum. Tony has certainly shown marked improvement during his relatively brief life span, particularly the last nine months, and there is no reason to believe that he will not continue to improve.

"The adoptive home has obviously made a momentous contribution to Tony's social, emotional and mental growth. He has found love, acceptance and environmental experiences which have enabled him to become a happy, secure and responsive child, as well as one who can now demonstrate on psychological tests a performance approximating the normal."

The change in this child in this adoptive home, fully substantiated by objective evidence, is dramatic, startling and even tragic.

Tragic? Yes, because one can think of the many other such children penalized by the

cautious conservatism of social workers and deprived of the "best home" because we lack the courage to take risks with the right adoptive families, which we also usually have to make a special effort to find. The criterion of what makes adoptive families "right" is, of course, a different subject. That the families have to be carefully studied and especially chosen is obvious.

Tony's adoptive family, highly educated on both sides with own children of superior intellectual endowment, never doubted the powerful influence of love, security and proper attention to physical problems in helping this child to normalcy.

Social workers are the greatest advocates of working with reality factors. Are we, however, always sure what is reality? Realistically, what do we scientifically know for certain about predicting adult potential from heredity, early physical development and infant psychological tests? Isn't reality uncertainty and unpredictability about the future?

Dr. William M. Fischbach, a physician who is also an adoptive father, points out that there is a degree of validity in all these approaches, but he feels strongly that the intangible something which is somehow brought out in interpersonal relationships must not be overlooked:

"The human will  
That force unseen  
Can hew its way to any goal  
Though walls of granite intervene."

Or, stated differently, "Through aspiration to the stars."

This philosophical approach to the whole

matter is emphasized again for us in Gilbert Highet's *Man's Unconquerable Mind*. Highet says the normal man "leaves large areas, perhaps two-thirds, of his brain dormant."<sup>8</sup>

No one can read this highly stimulating book, with its emphasis on the individual's unused reservoir of intellectual and other strengths, without wondering again about our theories of matching. Example after example of individuals who have outsoared their origins, of the limitless treasure of individual ability, of the inexhaustible power of the mind if subjected to challenge and stimulus, are given.

Social workers want to be as scientific as possible, but most of us know there is a plus in our relationships to our clients. Whether we call it Grace—someone's love, a gift freely given, and response to a gift freely given<sup>9</sup>—or by another name it is a factor in our practice. Similarly, it is a factor in relationships within an adoptive family.

In dealing with human beings we are always aware of the impossibility of our knowing all the answers. We feel deeply our obligation in adoption to do the very best we can for our clients—for the natural parents who trust us with their baby, for the adoptive parents who rely on our professional competence, and most of all for our primary responsibility, the baby. Yet we all know it is impossible to guarantee results. We have always maintained that natural families take what may come and face disappointments with their children. It seems grossly unfair to our fine adoptive families not to believe that they too can love a child for himself and can accept him as he develops. We firmly believe, based on considerable experience with adoptive families, that they need not be so protected. Actually, of course, we tend to believe that our averagely endowed child will do well in

<sup>8</sup> Gilbert Highet, *Man's Unconquerable Mind* (New York, Columbia University Press, 1954), p. 69.

<sup>9</sup> St. Thomas Aquinas, *Nature and Grace*, translated and edited by A. M. Fairweather (Philadelphia, Westminster Press, 1954), p. 157.



a "superior" home and therefore that the risk of disappointment is not great. Nevertheless, we feel it is a calculated risk and one that we should more frequently take.

We are not advocating the universal adoption of this "over placement" technique. Not at all. Just as the general policy of early placement of infants in adoptive homes is modified many, many times within an agency based on social, legal or medical considerations, so any such policy of "over placement" must be used with discrimination and caution after a careful consideration of all the factors involved.<sup>10</sup>

But it *should* be used. Not to do so is to

deny to many infants those tangible and intangible opportunities and advantages which democracy offers to them as their birthright and heritage.

The obligation of this reality should stimulate us beyond the human frailty of our personal fears and timidity. It should give us the courage to aspire to greater accomplishments for the children for whom we have been charged with such a tremendous legal, social and moral responsibility.

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<sup>10</sup> See John R. Wittenborn, *The Placement of Adoptive Children* (Springfield, Ill., Charles C Thomas, 1957) for additional evidence in support of this theory.

## Parent and child

If a child is with his parents at the time of the impact of a disaster, his reactions to this event may be greatly influenced by his parents' behavior. If the immediate response of the parent was such as to offer support to the child, this response indicated a fairly reliable supportive parent in whom the child could place his confidence. If the parent's response was a hysterical demand for help, then the child-parent relationship was seen to be reliably unreliable in day-to-day affairs.—Excerpted with the permission of the Institute of Living (Hartford, Conn.) from a review of "Patterns of Parent-Child Interaction in a Disaster" by Earle Silber, Stewart E. Perry and Donald A. Bloch, *Psychiatry*, 21 (May 1958), 159-67, in the *Digest of Neurology and Psychiatry*, 26 (August 1958), 351.

# Psychiatric examination of the child

The psychiatric examination of a child may superficially bear very little resemblance to the psychiatric examination of an adult patient. Nonetheless, the interview with the child—although it may be conducted on the floor during a game of jacks or with the patient sitting on the examiner's lap sobbing over a broken toy—remains essentially a reapplication of basic principles of interviewing techniques in a different setting.

In developing an understanding of the emotional aspects of a child's difficulties, the pediatrician, general practitioner, psychiatrist or other worker may at first feel uncertain in his approach to the child. Many unexpected, disconcerting situations

develop, and it is often not clear what to look for during the contact with the child. Frequently all that is obtained from the examination is an impressionistic recollection of some outstanding trait or performance rather than a well-considered appraisal of the child and the problem. The mental status examination is useful in evaluating the personality of the adult patient. There has been no comparable standardized guide, however, for the psychiatric examination of the child.

The purpose of this communication is to present a form for the diagnostic evaluation of a child which organizes the many inferences that may be drawn from interaction with the child. Space limitation prevents a discussion of the many specific contributions which have been made on this subject, but special mention should be

made of the monograph titled *Diagnostic Process in Child Psychiatry* (1). The writings of Erikson (2), Sullivan (3), A. Freud (4), Lippman (5), Gill (6), Witmer (7) and Nixon (8) have also been drawn upon freely.

## BACKGROUND

Before taking up the examination itself, it will be useful to review some general concepts that help put the diagnostic activity into proper perspective in the process of helping a child by means of psychiatric intervention.

The study of a child's difficulties must include an evaluation of the familial and environmental factors. In this paper, however, the focus is upon the child himself. It is helpful to keep in mind that while the doctor is going about his work the child is also busily appraising the doctor, and that the conclusions formed by the child will enter into the clinical behavior the doctor is observing.

The psychiatric examination differs from the medical or laboratory examination in that psychiatric examination, diagnosis and treatment go on simultaneously and cannot be separated from one another. Like a juggler, the examiner needs to coordinate the many aspects of his relation to the child. The emphasis in this outline will be upon organizing the information originating from the interview in such a way as to enable the doctor to act most effectively in behalf of the child and his problem. It is planned to consider what takes place during the psychiatric examination of a child, what is to be observed and tested. The problem of *how* to conduct the examination is outside the scope of this paper, as such skills are best gained under supervision and no fixed procedure for this can be easily described.

Prior to the examination, the doctor

should have some general plans to help him organize the raw data of the child's behavior. He should have some ideas, obtained from a previous contact with the parents, as to what to expect. The purpose of the examination is to determine the nature of the problem, whether or not treatment is indicated and if so, who is to receive it—the child, the parents or both. An effort is made to categorize the problem in the classification system used in general psychiatry, and the doctor accumulates the evidence that permits him to diagnose the presence of organic brain damage, a psychotic disorder, a psychoneurosis, etc. When psychopathology is found, the doctor evaluates its severity, seeking to clarify whether the disturbance is a situational response and transitory or whether it has become part of the child's personality. The examiner's estimate of the treatability of the disturbance or of the child's capacity to change is just as important as the recognition of psychopathology.

With this as our orientation, we can turn to a consideration of the psychiatric examination. It is to be anticipated that the items suggested in this study are not to be used during the interview in the same order in which they appear in the outline. Rather, the form may be useful as a mental check list of the various elements which enter into the examination.

## IDENTIFICATION

This is an orienting statement which forms the background and reason for the clinical evaluation of the child. The subsequent interview will attempt to answer the question implied here. Where the parent has a host of complaints regarding the child, it is important to identify the primary difficulty which is the most disturbing to the parent.



# *The outline of the psychiatric examination of the child*

## IDENTIFICATION

Name, age, sex, religion, color, ordinal position, reason for referral, who referred, first or second examination, etc.

## APPEARANCE

Build, facial expression, clothing, health, defects in hearing, vision, etc., personality traits, mannerisms.

## INTERPERSONAL RELATIONS

*Interaction with parent*—waiting room, degree and type of anxiety upon separation, response to reassurance, reaction upon rejoining parent.

*Interaction with examiner*—attitude: arrogant, suspicious, cooperative, etc.; capacity to relate; type of relation: trusting, controlling, erotic, etc.; role taken and role assigned to doctor; feeling aroused in reaction to patient; beginning compared to end of hour; first interview as compared to last.

## CAPACITIES

*Intelligence*—estimated level: knowledge, imagination, grasp of situation; potential capacity.

*Affects*—mobility, appropriateness, predominant moods, shame, anger, depression, anxiety, etc., shifts in tension, somatic expressions as sweating, blushing.

*Motor*—coordination, gait, muscularity, use of hands, body, activity pattern, inhibited, immature, hyperactive, etc.

*Speech*—clarity of diction, of ideas, defects, vocabulary, pressure, spontaneity, voice quality, etc.

## CONTENT

(Attitudes, feelings, ideas, etc.)

*Towards clinic visit*—reaction to visit, grasp of purpose, awareness of difficulties, reaction to symptoms, feelings about return visits, participating in planning.

*Towards self*—Behavior, appearance, body, sex, intellect, worries, fears, preoccupations, etc.

*Towards others*—parents, siblings, relatives, peers, teachers.

*Towards things*—pets, hobbies, possessions, money, food, school.

## PLAY AND FANTASY

*Play*—approach to and interest in toys, toys used, mode of play: incorporative, extrusive, intrusive, etc.; manner of play: constructive, disorganized, nurtural, etc., distractibility, play disruptions, etc.

*Fantasy*—wishes, dreams, daydreams, fantasies, ambitions.

## CLINICAL IMPRESSION

*Descriptive*—summarize personality structure.

*Dynamic*—major areas of conflicts, mechanisms of adaptation.

*Statistical*—use standard nomenclature and code number (9).

## PROGNOSIS

Benign, malignant, acute, chronic, with treatment, without treatment.

## DISPOSITION

Further diagnostic studies, need for treatment, treatability, psychiatric therapy, environmental control.

## TREATMENT

Individual, group, collaborative, consultative; frequency and estimated duration of therapy, goals, family management, countertransference impressions, general approach.

## APPEARANCE

A vivid description of the impression that the child creates helps to establish a mental picture of the kind of child being examined. The items listed make no attempt to exhaust the descriptive possibilities. Some further items could include family resemblances in the facial expression, whether the child appears older or younger than his stated age, details of body care such as bitten nails or unkempt hair. Gross neurological signs such as facial assymetry, disturbances of gait or nystagmus will suggest further medical investigation. The first few minutes of the interview may be regarded as having a far greater degree of intensity and therefore more significant influence upon the remainder of the interview than any other similar few minutes during the examination. Aichorn (10) has emphasized the importance of the quick impression in the beginning moments of the interview when recognition of the dominant attitude and feelings of the child enable the doctor to respond most appropriately to the child.

## INTERPERSONAL RELATIONS

Observation of the child in the waiting room often furnishes valuable clues as to the nature of the parent-child relationship. The physical closeness or apartness of the child and the parent, the attitude of the parent as expressed in voice tone and manner of handling the child, the reaction of the child and the parent to the separation—all these are noted in the first few moments of the study.

As a general procedure, it is preferable to plan for at least two diagnostic interviews. While one may be sufficient (and at another time three or four sessions may be indicated), two interviews permit the examiner to observe the changes in the

child's responses to his visits. A child who remains detached and stolidly defensive in successive interviews presents a different task in the planning of therapy from the one who shows a progressive ability to relax and to relate. The former indicates that the character formation has already become involved and the child will probably require individual therapy regardless of any subsequent alteration in parental attitudes and behavior. In the latter case, the changing nature of the relationship indicates a greater elasticity of the child's personality. This in turn suggests that the attempt to change the parents' attitudes and relationship to the child will be an important part of the treatment plan.

The feelings aroused in the examiner in reaction to the child are another valid source of data. At the descriptive level, a child may appear to be silent and inhibited. Yet one child may be frozen with fright, another rigid with anger, and still a third provocatively teasing. The most sensitive recorder of these different moods remains the emotional response of the examiner.

## CAPACITIES

Here is described both the endowment that the child possesses and his ability to use it freely. This includes the enduring assets as well as the outstanding liabilities which are observed in the child. The level of functioning and the degree of stability in maintaining this level form a base line against which future progress or regression can be measured. The manner of functioning that the child demonstrates may suggest the therapeutic approach to be used. One child may be over-intellectualized and need help in relation to isolation of emotional feelings. Another may act impulsively, indicating difficulty in controlling motor activities. Still another may be un-

usually sensitive and shrink from close contacts with people.

The examiner is alert for fluctuations in the level of performance—such as flashes of intelligence, which help in the differential diagnosis of a brain-injured child or a mentally retarded one.

## CONTENT

It is helpful to gain some understanding of the child's ideas and feelings about coming to see the doctor. The preparation of the child for the examination should be reviewed beforehand with the parents. It is usually quite revealing to observe the results of preparation, not only in terms of the child's personality but also in terms of the parent-child relationship. There are many possibilities to explore: The child may not have heard what was said to him, or he may have distorted the information, or the parent may have been unable to be direct with the child in this matter.

During the examination the child should be prepared by the examiner for other procedures such as psychological tests, and for future visits. The child's ability or inability to express his feelings about such important figures as his parents helps the examiner to map out the sensitive areas in the child's living experiences. The over-all total response of the child to the new situation throws light upon the character formation and the defenses that the child characteristically uses in meeting life's stresses. The child's appropriate or inappropriate response to the clinic setting furnishes an opportunity for estimating the capacity to adapt.

The doctor needs to be familiar with the series of problems that each child meets in growing up and to evaluate the current difficulties in terms of the successful or unsuccessful integration of these successive

stages of psychosexual development. The individual problem may appear in the form of a currently unrealistic belief about the world or about himself. It may show up as an exaggerated feeling or absence of feeling, or an inability to act, or a preoccupation with one particular activity, or indeed any combination of any or all of these. Once identified, the tendencies should be cautiously tested to see whether it is flexible and reversible or whether it has become isolated from the influences of daily living and part of the character of the child.

Throughout all of his efforts to understand the child, the examiner does not simply probe for factual material but creates the atmosphere which is most favorable for a spontaneous interchange of matters of interest to the child.

## PLAY AND FANTASY

The child's fantasy life and play activity offers significant indicators of the unconscious determinants which enter into his behavior. Through these media, as through dreams, the needs and wishes that are too anxiety-provoking to be directly expressed find discharge. A child can be encouraged to share his fantasies by such questions as "If you could make three magic wishes, what would you wish for?" or "What do you want to be when you grow up?" or "What is your favorite program on television?" The doctor can express his interest in hearing about dreams which the child enjoyed and dreams which were frightening to him. This tension-releasing function of fantasy and play is not only of service to our diagnostic purpose, but also indicates the therapeutic openings which can be used in helping the child gradually express his desires and fears more freely.

While the emphasis in this paper has been upon a verbal interchange, at times it



may be desirable to use play materials such as dolls, clay or pencil and paper to help the child express himself. The experience and personal preference of the examiner will help decide the choice of such aids. A few dolls in a family scene may help the child relate how he feels about an emotionally-charged aspect of his home life. If he shows an interest in drawing pictures he may be asked to tell a story about them. As the child talks, the examiner listens for the particular affect, such as shame or anxiety or anger, which appears as a persistent thread woven into the fabric of the stories and dreams. It is this thread that is so important in understanding the painful feelings against which the child needs to defend himself.

The mode of play item has been adapted from Erikson (2) and refers to the principal way that the child functions or, to put it differently, to his main style of life. For example, the hyperactive child who is unusually curious and prematurely pugnacious, who literally gets into everything, may be using this intrusive form of behavior to express unresolved phallic strivings. Sudden alteration or disintegration of a play activity is carefully noted as a sign of increasing tension, and the examiner relates the disruption in play to what has just preceded it.

## CLINICAL IMPRESSION

These separate diagnostic impressions summarize the significant findings which have emerged from the examination. The child is described as to what type of a person he is and how he tends to deal with his difficulties. From the review of his observation and participation, the doctor also infers what the sources of the difficulties are. The value of a statistical diagnosis lies more in the direction of recording information about

similar clinical problems in order to gain a broader base for our understanding rather than of being of immediate clinical use with the child.

The diagnosis of psychopathology in the child is less definitive than the diagnosis of psychopathology found in the adult. The immaturity of the child and the flexibility of his defenses allow for a shifting of patterns of response to stress. An understanding of this prepares the doctor for the discrepancies he will often meet where the child's reported problem is so different from what is actually observed clinically. The interview is part of a total dynamic interplay of forces, and the relatively isolated sample of behavior which is noted will limit the scope of conclusions to be made. Still, a working hypothesis that allows practical, realistic action to be taken can almost always be synthesized from the various data that have been accumulated up to this point.

## PROGNOSIS

A projected course of events may be considered in terms of a historical review of the problem as it has developed up to the present time. While the doctor is unable to predict every adaptive stress that the child will face, he may be able to anticipate some. For instance, it may be expected that an 8-year-old patient who shows a potentially psychotic disorder will have considerable difficulty in handling the problems of adolescence, and perhaps may be unable to manage them with success. Social and economic realities, the stability of the family unit, the intelligence and concern of the parents are some of the significant factors to be weighed in the prognosis. To these the doctor adds his judgment of the malignant or benign quality of the child's difficulty as it appeared during the examination.

## DISPOSITION

Here the doctor recommends the next step to be taken in the management of the child's problem. The primary decision to be made is in regard to the treatability within the setting where the child is examined. In a clinic where different workers may see the child and his parents, the assignment of the collaborating therapist is considered. Recommendations for further medical studies are also made when necessary.

## TREATMENT

Once the need for and the feasibility of psychotherapy has been established, further details of treatment are to be considered. The decision of who is to receive treatment—the child, the parent or both—is important. The type and frequency of therapy—whether supportive or uncovering, individual or group—should be considered. The goal of therapy and the problems that might be anticipated should be recorded as well. These matters are not regarded as fixed and unalterable but are to be changed when indicated.

## DISCUSSION

While the technical problems of interviewing do not lend themselves readily to diacritical analysis, it may be fruitful to reflect upon some of the special situations which often arise in work with children.

Recognizing that the child often comes unwillingly, the doctor is prepared to meet and help his patient, who is frequently most uncooperative. If possible, the doctor sees the child alone in order to observe how he handles himself when he is on his own. With some children, however, the separation may stir up such an overwhelming amount of anxiety as to threaten to disrupt self-control. In these situations the parent is asked to accompany the child until a

tolerance for the separation is developed. The principle here is the same as is found in all fields of medicine: The doctor himself should do no harm and must not introduce a new traumatic experience into the problem.

Should the child angrily refuse to accompany the doctor to his office, the doctor responds as appropriately as possible to each specific situation. He accepts the child's anger as an expression of anxiety over the examination. At the same time, he helps the child avoid feelings of shame which could arise afterwards if infantile, regressive behavior were allowed to control the situation. This is accomplished by the firm insistence that the examination be carried out. By his own direct participation the child has the opportunity to see that his fears about it were unrealistic. In the case of a pre-school child the examiner may simply pick up the child in the waiting room and carry him into the office. This, however, would be humiliating for a child of school age, who is no longer accustomed to such physical control by parent-figures; here the doctor would be acting more appropriately to take the child firmly by the arm and lead him into the office. This illustrates an important point, namely, that the doctor needs to adapt his own behavior and expectations concerning the child's performances to the age and personality of each patient he sees. The needs and problems of the pre-school toddler are different from those of the adolescent, and each requires a modification in the clinical approach used by the doctor.

The question of the use of physical force is often a source of personal difficulty in professional work with children. The doctor is ready to act whenever necessary to keep the situation within limits of comfort and safety. If verbal controls do not suffice, then physical control may be required. The

confident readiness and unambivalence of the doctor is actually reassuring to the child, who may have anxiety over his own lack of self-control.

The real dependence of the child upon adults requires that the doctor be aware of his dual role. He is both a parent-surrogate as well as a physician and cannot remain completely impersonal in his relation to the child. In an interview with an adult patient who breaks down and starts to cry, the doctor waits until he has regained composure. In the case of a young child, however, the doctor does not remain so detached, but offers the child his own handkerchief or draws him close for physical comforting. In working with the pre-school child, the physical nearness of the examiner may be used to help establish the relationship. It is often of value for the examiner to pick up a child who is sitting alone and feeling very alone and hold him on his lap. If a child remains absolutely silent in the face of the examiner's attempts to relate to him, it may be helpful to gently take the child's pulse rate. A racing pulse suggests that the child is struggling to control inner tension, while a relatively normal pulse rate indicates a greater degree of ego participation in the resistance.

In this fashion the diagnostic process demands active participation by the doctor so that bits of behavior can be properly evaluated. A careful consideration of the physiological factors, psychosexual development and cultural background is necessary for the analysis of any one clinical problem.

Since the major portion of this paper has been centered around the facets of examination and diagnosis, a reconsideration of therapy during the interview should be added to restore balance in this matter of helping a child in difficulty. Since the child is most often brought to the clinic because of the parents' concern, his initial position

is a passive one. The symptomatology for which the parents are seeking help may in no way correspond to the worries or concerns that the child has about himself. Part of the purpose of the visit, therefore, from a therapeutic point of view, is to interpret the interview in terms of what the child himself wants or is worried about or would like to be helped with. We seek, at all times, to engage the child's own participation in the therapeutic process. If this concern with the child's own preoccupation is lacking, the examination will tend to remain an objective description of the child and his functioning, and the child's own emotional investment will be minimal. Ideally, his contact with the doctor should be a constructive experience in living for the child. It should expand his trust of adults and begin to supply the help he needs.

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## Communication between psychotherapist and teacher in treatment of the severely disturbed child

Johnny is a patient in Rochester's "EE" unit (for the "emotionally exceptional"), an experimental class for 10 severely disturbed boys. It is staffed by a full-time teacher and a full-time group worker, and aims at providing a therapeutic experience in everyday living and learning for these children. Each patient is also seen regularly in psychotherapy, usually by the clinical psychologist or psychiatric social worker attached directly to the unit. In some cases, however, the children are seen in treatment by other clinicians not immediately connected with the unit. Such was the case with Johnny who was in treatment with a

psychotherapist at a local community clinic. For some months, teacher and group worker had been complaining that this arrangement left them with too little understanding of Johnny's behavior, and that they felt themselves confused in their efforts to work with this child—whereas they had regularly scheduled meetings with the therapists of the other children to clarify their ongoing problems. Now the point had come where teacher and group worker were very much at an impasse and felt that they must insistently invite Johnny's therapist to a conference around their problems with the child. Johnny's therapist was obviously unhappy over this invitation at first, but after much prodding the conference was scheduled.

The group worker opened the conference with the remark that he and the teacher would like to understand more of Johnny's

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At the time Dr. Charny wrote this paper he was with the Board of Education of Rochester, N. Y. Since then he has joined the staff of the Oakbourne Hospital in West Chester, Pa., as chief clinical psychologist.

problems in a way which would help them in their everyday work with the boy. On hearing this, the therapist—obviously a reluctant hostage at this meeting to begin with—openly expressed his reluctance to go into the full dynamic picture of his patient, and did so in a manner that aroused much resentment from the teacher and group worker. There followed a fairly direct exchange of verbal blows until finally the therapist agreed, though in a somewhat angry and condescending way, to sketch Johnny's progress in treatment to date. This he did, very lucidly in fact, though he confined himself largely to presenting a broad overview of Johnny's reactions to the treatment situation.

The teacher and group worker then proceeded to pose for the therapist their specific problems. They pointed out, for example, that Johnny had taken to climbing up on the storage closet in the classroom and stayed there, moping, for some time; they were unsure whether Johnny was ready for them to make vigorous attempts at drawing him out from this withdrawal or whether he should be left alone for the most part at this stage of treatment. Another typical situation which concerned them, they continued, was that even when Johnny remained in the physical presence of the other children he characteristically involved himself so intently in clay modeling that he was virtually left out of the group psychologically anyway. Here too they needed to know whether to encourage him to leave his modeling and enter into a more aggressive interaction with his classmates or to leave him to his self-expression in clay. Still another question which was posed for the therapist was whether Johnny should be encouraged to travel to and from school on his own as some of the other patients had recently begun doing, or should continue to be transported by the school

bus. Finally, the teacher felt that he needed help in deciding whether the time had come to introduce a concerted program of reading instruction for Johnny, or was he still too engrossed in his defensive consolidation to tackle this step forward?

To these well-formulated questions, the therapist's initial reaction was derisive and, not insignificantly of course, self-deprecating. In effect, he took the position that a therapist doesn't know the answers to such specific questions. "How should I know?" he insisted, as if his work with the child bore no implications for the reality of the child's life outside of the treatment office. In the dispute that followed, the therapist concluded angrily, "We (therapists) can't be God!"

Happily, with some gentle and well-meant give-and-take on both sides, the discussion was able to proceed to a consideration of the specific questions posed by teacher and group worker, and a meaningful treatment plan did in fact finally emerge. Specifically, it was agreed that this did seem an appropriate time to encourage Johnny actively away from his withdrawal to the storage closet as well as from his self-protective engrossment in clay modeling. It was also felt that Johnny should be urged at this point to undertake traveling to and from school on his own, and that the teacher might feel free at this time to initiate a more emphatic program of reading instruction for the youngster.

The discussion was so successful, in fact (in part perhaps because of the very tension which had been generated earlier in the meeting and which now needed to be resolved), that a still more ambitious plan emerged from these considerations: They would work towards a trial placement for Johnny of several hours a day in one of the school's regular grades. It was agreed that if Johnny succeeded in this trial place-

ment he might be discharged entirely from the special "EE" unit the following year and returned full-time to a normal grade while he continued in treatment at the downtown clinic.

Now, a year later, this plan has taken effect, and Johnny continues to make significant strides towards recovery.

#### THE ADVANTAGES OF COMMUNICATION BETWEEN PSYCHOTHERAPIST AND TEACHER

It has often been observed that patients are in treatment 24 hours a day and not merely for the one hour or so that they spend with their therapist, even when the treatment contacts are restricted to one or two hours a week. With many patients, of course, including children, the therapist need not concern himself very much with the reality figures in the patients' life outside his office. Usually this is the case with patients whose ego defenses are sufficiently intact so that they are able to swim along relatively successfully with the mainstream of their community—whatever the toll they pay in personal anguish or inhibition within themselves. Ultimately, the therapist knows, a successful working through of the patient-therapist relationship in the treatment situation itself will free the patient to more rewarding interpersonal relationships and the enjoyment of greater successes in his everyday life. The patient's real life is brought into the treatment situation for analysis and working through, but the therapist's protection and his direction of the treatment process need not be extended to the patient's ongoing activities outside.

There are other patients with whom such a psychotherapeutic approach is not desirable, let alone sufficient. The psychotic adult, for example, needs the protection and therapeutic direction of a hospital community to maintain and strengthen him

even as more focused psychotherapeutic efforts may be initiated. The physically handicapped, the alcoholic and certain types of character disorders are other examples where "environmental manipulation" and "therapeutic communities" may be indicated. Children, whose tender egos are still very much in development above and beyond the inroads of their illness on their effectiveness in everyday life, much more frequently require a more encompassing treatment program.

Outstanding in this respect is the desirability of involving the child's parents in the treatment process, since therapeutic gains with the child himself will often be short-circuited unless the parents too are able to change along with him. Sometimes this is impossible, or the child's disturbance is already so severe that he cannot be helped in his natural life-setting alone. The continued growth of residential treatment centers for children in recent years is in answer to such needs. These centers are the ultimate in a broadened concept of treatment extending to the child's total life situation.

Even outside a total treatment setting, however, there are many instances where the child's progress and treatment may be accelerated or even depend largely on well-planned "corrective emotional experiences" in his daily life. Rochester's experimental "EE" unit, for example, is an attempt at a halfway point between the total residential treatment setting and the treatment of the child in the normal community in that the child's school hours are spent in a flexible treatment setting designed to provide him with a proving ground for his newly acquired strengths from psychotherapy and to serve as a stimulus to the more focused individual psychotherapeutic process. Such a program is necessarily expensive and limited to few patients, of course.

There are still other situations where in-



dividual psychotherapy is not available to the disturbed child, but where efforts are made to provide a therapeutic group experience which will hopefully help him at least to modify some of his more exaggerated symptoms. Louis Hay has described, for example, the New York City plan for classes for disturbed children where the clinician functions as a coordinator and resource person for the teachers, the teachers being the "only trained social representatives who are in a position to contribute toward the better adjustment of the greater number of disturbed children."<sup>1</sup>

Finally, there is by far the larger group of children who may be able to continue in their normal school settings as psychotherapy progresses with the school psychiatrist, psychologist or social worker—and often enough a private psychotherapist—so long as the therapist is sufficiently flexible to provide ongoing support for the teacher and principal, who must live in daily contact with the youngster and his provocatively disturbing behavior. In fact, the therapist may find often enough that not only is he able to help the school community to tolerate the child during the treatment process, but that there are sensitive teachers who may be able (in consultation with the therapist) to contribute effectively to the child's treatment through the teacher-pupil relationship. Naturally, such cooperation presupposes a teacher and a school community that are sufficiently free from manifest emotional disturbance and are personally and professionally dedicated to helping the child in his growth as a person and not only as a Univac-like storehouse of information. Often enough, teachers and schools are unhealthy agents of repression and suppression; but then again, often enough, the therapist will find sincerely warm and mature educators who

are eager to participate in the treatment process.

In the therapist, the treatment process requires a person who does not panic at the first signs of anxiety in the teacher or the school, who is able to recognize the impact of his disturbed patient on those about him, who does not become defensive and offensive because of the insults he feels they are directing towards the patient with whom he himself identifies, and who respects the professional status of the educator. The therapist must be able to communicate an understanding of the child's dynamics in the real-life concepts of the layman without retreating into wordy technical formulations of psychodynamics; these would only betray his own fundamental lack of understanding and feeling for the unconscious processes that are determining the child's behavior in the world in which he lives. In the final analysis, the detachment of the psychotherapist from the teacher as well as from other significant figures in the child's life—when there are possibilities of cooperation and when a broader treatment approach is indicated—betrays the therapist's defense in professionalism which is intended to mask his own anxiety about his competence as a therapist and, ultimately, his adequacy as a person.

The therapist who succeeds in establishing an effective working relationship with his patient's teacher will find many rewards accruing to the child, the teacher, the therapist himself, and ultimately to many other children in the school community (who, after all, are also the concern of the sincere clinician devoted to his calling). The clinician who takes the trouble to think back to

<sup>1</sup> Hay, Louis, "A New School Channel for Helping the Troubled Child," *American Journal of Orthopsychiatry*, 23(1953), 676.

the early days of his own training soon recalls the many moments of bewildering confusion in these first exposures to the unreasonable, strange, provocative, often uncanny behavior of his patients; he is then able to feel more sympathetically the emotional plight of the teacher who is confronted by such children. Frequently, a teacher left to his own resources under these circumstances will build defensive retaliations against the child, which can be devastating in their impact. Happily, we often see that simply knowing that a child is under diagnostic study (or, better yet, under treatment) will forestall such unconscious reactions by the teacher, who now feels that someone else is sharing his terrible burden and that if he is patient relief will be forthcoming. At the very least, a general intellectual understanding that a youngster has had a "hard time" in his life, or that he is a psychiatric patient, will help a teacher invoke certain defenses against the angry retaliatory feelings that may be welling up inside. In reality, working with the teacher and school will often forestall their taking serious administrative action which can be permanently injurious to the patient, such as demotion, inappropriate placement in retarded grades and even total exclusion from school. At best, communication between therapist and school may help the teacher develop a meaningful emotional understanding of the disturbed child and an understanding of his own relationship difficulties with this child around which specific treatment techniques may be attempted in the classroom.

Billy would throw a tantrum every time gym class was scheduled or, more subtly, just before gym time, so that he was already in too much "hot water" to be allowed to go on with his class. Sometimes he would simply refuse defiantly to go on to gym; at

other times he would actually run away and wander off in the school building; on still other occasions he would launch into fairly serious acting-out defiance, including destroying school equipment. On these occasions the teacher would characteristically insist on Billy's going along with the group, but with predictably unsuccessful results, of course. Needless to say, the consistent outcome of this struggle was a seriously upset teacher and a seriously upset child.

In conference with the teacher, the therapist was able to communicate the tremendous phobic anxiety that Billy suffered around the gym, disguised in his angry, negativistic acting-out, and explained that the threat of close contact with other boys was too great for him to tolerate at this point. It was agreed that instead of attempting to force Billy into the gym activity, they would work out with him more socially appropriate ways of gaining permission to skip this class. The teacher explained to Billy that he understood how upset he was about gym, and said that of course it would be possible for him to have some other activity during these periods so long as he was too uncomfortable to go along with his class, but stressed that the important thing was that Billy be able to ask his teacher to be excused instead of resorting to all the negative techniques he used to escape.

The result of this approach was that much of Billy's severe acting-out in school soon ceased, and a warmer relationship developed between him and his teacher which proved beneficial to his growth in many subsequent situations. From the point of view of the therapist, the teacher's efforts helped his patient to acknowledge the anxiety which generated his symptomatic behavior, and accelerated clarification of the anxiety in treatment. During that year, Billy was able to work through in

treatment the homosexual panic that was triggered by gym activities, and a year later—on his own initiative—began taking part in gym classes.

Paul was a 4th grader who had been doing failing work for several years and was recommended by his teacher for placement in a class for retarded children. On mandatory screening by the school psychologist it was discovered that Paul was in fact an unusually gifted youngster who even at that time was able to achieve a Stanford-Binet IQ in the superior range. Further clinical appraisal suggested that Paul showed surprisingly hopeful potential for treatment, especially if his family could also be involved in treatment as indeed they soon were. Paul began treatment and on the therapist's recommendation was promoted to the next grade at the end of that year, even though his work still showed no significant improvement. The therapist encouraged the teacher not to hesitate to communicate to Paul on the level of his known intelligence even though she should not immediately expect any striking changes in his performance. Following her initial amazement and utter disbelief, the teacher began to report a significant change in her perceptions of Paul and a feeling of growing warmth in her relationship with him. At this point the teacher became so taken with him that she was reluctant to record the failing grades he was still making and instead suggested that Paul be given "T" grades for trying so that he wouldn't be "hurt." The therapist helped her to understand how Paul needed to learn to evaluate realistically how poorly he did in relation to his real abilities, and that moving in the direction of minimizing his failings would be as harmful to him as failure to recognize his real potential.

Paul is now continuing in treatment and

recently achieved a series of excellent grades for the first time in his school life.

One important result of effective ongoing communication between psychotherapist and teacher, and especially in a residential treatment setting or a school treatment setting such as Rochester's "EE" unit, is that the teacher does not feel left out of the treatment program, a "second-class citizen" to the omniscient clinician who seems to be enjoying all of the prestige and emotional rewards of the patient's progress. A parallel that comes to mind for the clinician who has been associated with a progressive psychiatric hospital is the tremendous boost in the morale of nurses and attendants who are included on the professional team, and the truly productive work they do where their professional status and skills are respected. Such settings show especially clearly how a well-formulated total treatment plan provides a flexible framework for increased understanding of the patient, encourages more acute and insightful observations, and provides the directions for future modifications of the treatment plan as they are needed and understanding of the patient permits. Even the therapist who is inclined to emphasize almost exclusively the focused psychotherapeutic session will find that periodic communications with the patient's teacher may help him to understand features of the case that might otherwise remain obscure for some time.

Harold is a youngster with undescended testicles who was referred for treatment because of severe anxiety and mood swings. It soon became clear that the undescended testicle condition was an important focus of Harold's character problems and symptomatic reactions. For example, later in treatment it turned out that Harold thought the real word was "intesticles" (even though



the word had already been used many times before in previous sessions) as if to say that he dared not conceive of his testicles being out and therefore exposed to the dangers he felt. Still later Harold was able to say that he didn't want any testicles because they weighed him down, that instead he wanted to be a teddy bear and in this disguise continue to enjoy the love of his mother, which he felt would be lost if he no longer concealed his genital urges. In his behavior with other children he showed a tremendous pressure to exhibit himself and to dominate others to the point where he regularly built up into literally exhibitionistic frenzies.

One day Harold became so upset that the teacher called his therapist, a school psychologist, on an emergency basis. Harold was so upset on this occasion that he even went for a kitchen knife in the playroom (although the therapist felt there was no realistic danger of his using it). His verbalizations centered insistently on angry threats that he wanted to hit his teacher "in his big balls." He belabored this feeling so intently that the therapist volunteered the interpretation that he seemed to be concerned about the condition of his body and was furious at his teacher for being so big because he himself felt so insignificant that day. This interpretation had the significant effect of calming Harold down and permitting him to return to the classroom a short while later. He was able to get through the rest of the day without any untoward incident. Later, in conference with the teacher, the therapist learned that just that morning Harold had been examined by the school physician. The teacher was greatly relieved by the therapist's helping him to understand how the panic that followed was triggered by Harold's intense anxiety around the physical examination.

Later in the year when Harold was to receive an injection from the school physician the teacher consulted the therapist about preparing the child for this ordeal. Arrangements were made to capitalize on the anxiety that was triggered by this experience by scheduling a treatment session shortly thereafter. After two panic withdrawals to the therapist's office just before the physician could inject him, Harold went back a third time and was able to "take his medicine."

There is, however, also the other side of the coin to therapist-teacher communication which advises against unduly frequent or even regularly scheduled contacts in many situations, let alone in the numerous cases in which the therapist will not need to initiate any contact at all with the teacher. School clinicians especially, because of their responsibilities to school administrations, are prone to find themselves saddled with ritualistic obligations to meet with teachers at little gain to their patients. It is not unusual, for example, to find a teacher acting out his own unconscious needs in repeated bids for the clinician's attention, but because the contact is ostensibly around a child's needs and is further disguised by professional protocol it is often very difficult to work out the real issues.

Above all, there is the therapist's responsibility to his patient to insulate the treatment situation from everyday family and community pressures. The delinquent youngster, for example, requires a patient, concentrated acceptance from the therapist who, by his own conviction as well as the understanding of the community in which he is practicing, should be separated from those reality figures who necessarily must deal with delinquencies as they arise in any community. To introduce the issues of a youngster's outside misbehavior into treat-

ment prematurely may destroy the possibilities of a therapeutic relationship.

Danny is a youngster with a history of hyperactivity, lying and stealing. In treatment, however, many weeks passed by with Danny guardedly avoiding displaying his symptomatic behavior. He was certainly a frisky youngster but not unmanageably hyperactive, and he used his treatment appointments to enjoy playing games with the therapist amidst a good deal of bodily cuddling. At the same time, however, his behavior in school continued to be erratic and uncontrollable, and he was periodically getting involved in serious misbehavior which he denied with seductive sincerity. On the basis of this information from Danny's teacher, the therapist began to inquire actively into how Danny was getting

along in his class, and soon Danny's problems were appearing progressively in the treatment situation itself. Unhappily, the result was not the acceleration of treatment that had been hoped for. Instead, bringing the issues of Danny's delinquencies into treatment before he himself could do so spontaneously left him unable to separate his therapist from the school administrators and ultimately from his own punitive mother. It was eventually necessary to terminate treatment and refer Danny elsewhere for the help he needed.

In the final analysis, effective communication between the psychotherapist and teacher requires of both mutual respect and sincerity of purpose. Therapist and teacher will find such professional cooperation a stimulating challenge and rich in its rewards for all.

## Cooperation

Certainly, the benefits of further cooperation are unlimited. To bring about more of this kind of accomplishment, we must eliminate unproductive rivalries and interminable wrangling which do immeasurable harm to our cause and bring public discredit upon both of us. It takes two to feud; two to quarrel. But these same two can unite their efforts; they can pull together; they can work wonders for the people they serve. As Thomas Carlyle wrote: "Men's hearts ought not to be set against one another, but set with one another, and all against evil only."—Gunnar Gundersen, M.D., president of the American Medical Association.

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MORRIS PARMET, M.D.

## Flexible use of child guidance personnel in a rural medical center

Comprehensive medical care today recognizes the importance of balance between the physical and the emotional well-being of the patient. The concepts of good patient care have extended beyond the confines of the hospital into the community. In somewhat the same way, we shall be describing a child guidance service that has moved beyond treatment of the individual patient and his family into a concern for the general mental health of a community. It has done this as part of a comprehensive program of medical care being offered in a rural area.

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Dr. Parmet, who is director of psychiatric services at the Hunterdon Medical Center, presented this paper in New York in March 1956 at the 33rd annual meeting of the American Orthopsychiatric Association.

The setting is Hunterdon County, N. J. (population 45,000), and the program takes place at the Hunterdon Medical Center in Flemington. In the early days of planning this medical center, something broader in scope than the typical small county hospital was envisioned. Aware of an almost total lack of health and welfare services, far-sighted members of the community planned that this medical center would encompass such services or provide leadership in their development. The board of trustees underscored this thinking in their philosophy that the emotional well-being of the patient was to be an integral part of patient care at the medical center.

Therefore, when the Hunterdon Medical Center opened its doors in July 1953, among the staff, composed of the county's general practitioners and nine full-time specialists,



was a child psychiatrist, a psychologically oriented pediatrician and a supporting staff consisting of a psychiatric social worker, a clinical psychologist and a public health nurse consultant. This staff reflected the vitalizing role which the child guidance service was to play in the new program.

With a focus on the preventive aspects of psychiatry, a child guidance clinic was projected to replace the only previous psychiatric facility in the community, a traveling state-operated clinic which had served the area one day a month. The establishment of a child guidance clinic was also to provide a structural base from which other activities in mental health would follow.

The conferences and meetings with a cross section of local groups which ensued opened up for the child guidance team an awareness of the paucity of social resources in the area. Also, in meeting after meeting numerous troubled situations were mentioned. Whether services would be used was not known, but it was correctly assumed that Hunterdon County had its share of mental health needs. The nature of these needs pointed up immediately that the job to be done went far beyond the confines of a treatment service and would include mental health education and orientation as well as the promotion of mental health concepts in the wider community. This would have to be accomplished by a numerically small staff simultaneously carrying on a program of treatment.

To carry out their objectives, however, the child guidance team soon found auxiliary assistance within the very structure of the Hunterdon Medical Center. The inclusion of a psychologically oriented pediatrician and public health nurse consultant in the table of organization meant that sound mental health practices in medical care were developing in the center and reaching out into the community concur-

rent with the operations of the child guidance team. With the recognition that in such a small community and with such limited staff it would be uneconomical to duplicate efforts, it became necessary to establish in fact as well as in name a coordinated mental health team.

This now cohesive group began to examine the goals of the medical center in its mental health activities, their relation to ongoing programs and, in addition, the special skills inherent in the mental health team. It recognized the slow and uncertain use of the child guidance service in contrast to the more active use of treatment services for adults, and assessed the requests being received for education.

To give further background to this picture, it should be emphasized that this highly trained group of professionals in mental health had not come to Hunterdon County as a result of any organized movement to bring such services to the citizenry. This community had not experienced the learning process and the travail so common to communities seeking a mental health program. The community had wanted good medical care and had accepted the inclusion of mental health facilities as one aspect of this, but did not yet know their use or value.

The provision of the existing program had been made possible by a grant from the Commonwealth Fund in recognition that the community was as yet not ready to bear the cost of mental health services, although the medical center saw them as an essential part of its program of comprehensive medical care.

The mere provision of the services did not, of course, imply community readiness for their use, and our task was to explore the spots at which community readiness and our own skills could meet. We were aware of resistances which would be encountered related to our very newness and to the real

or implied threat that the professionals posed for those individuals already carrying some type of mental health responsibility. In addition to providing treatment, we considered the possibility of providing intensive mental health education to key personnel in the community, such as teachers and ministers, so that they could presumably apply "mental health first aid." We also considered the feasibility of setting up a program of preventive intervention. Both of these concepts, however, imply a more aggressive role on the part of the professionals. For them to be successful, there would have to be more reaching out from the community, some evidence of desiring and supporting such programs. Our early experience showed that it would be more expedient to revert to the sound principles of letting the people of the community know what was available and providing them with an opportunity to move towards the utilization of our services at their own speed.

The way in which this began to unfold is best portrayed through the activities of the members of the team as they operated separately and collectively. At times we will use the phrase "mental health team" activities almost interchangeably with "child guidance unit," and in truth our developing way of operation had the pediatrician and nurse consultant operating peripherally as members of the child guidance service, just as in other areas the child guidance unit and nurse consultant served as appendages of the pediatric service. Although we had our separate and individual existences, there were special areas of professional endeavor where we coalesced in our performance. To the degree that individual strivings could be subordinated to overall needs, so could a small group hope for success in a program with numerous and far-reaching tentacles. We cannot describe all of the activities of the

team but will attempt a capsule representation of each team member's efforts.

Within the medical center itself arose an opportunity for collaboration of the obstetric service and the team in a request to set up classes for expectant parents. The psychiatrist and the pediatrician participated but the actual leadership was assigned to the nurse consultant. Out of her leadership came our realization that in this team member we had a person with skills and interest in teaching normal growth and development at a group level. And as later groups formed in the P.T.A.'s, in the adult education schools and in the medical center, she began to lead discussions concerned with the emotional problems of living at a generalized level.

Soon new opportunities presented themselves which gave us entry into established community structures. A local township requested a demonstration program in school health. Our pediatrician, working primarily with children entering school for the first time, used the clinical psychologist and nurse consultant in his program of evaluating potential difficulties in school performance related to physical and emotional problems. The clinical psychologist was then made available to another township at their request to demonstrate the specific role of a school psychologist. In this she was related to the school's focus on learning problems in general, rather than to diagnosis and treatment of a specific child.

The psychiatric social worker, being also director of social services for the hospital, was in a position most sensitive to the overall lack of community services, and together with other community workers began to study and evaluate existing and potential needs and services.

The psychiatrist carried over-all responsibility for the coordination of mental health



activities as well as for treatment services to children and adults. His own educational activities, although including lay and parent groups, were focused on helping allied professionals to enlarge their own areas of competence. In addition, because of his integration into the hospital's program of medical care he had an opportunity for the psychological orientation of all staff, medical and non-medical, professional, student or volunteer.

But not only was the psychiatrist used in a variety of ways to extend good patient care; the entire team was available for evaluation, consultation and the implementation of sound medical care practices in nursing and after-care planning. The team was, of course, most closely related to the pediatric service as participants in weekly ward rounds, pediatric conferences and individual consultations. From the use of psychiatric consultation alone developed the active use of the team to implement such mental health concepts as the inclusion of parents in the care of the hospitalized child.

In the extension of services made necessary by the many facets of the program it was seen that early symptoms of behavioral disorders might well be treated by the pediatric service. In other instances the pediatric floor might be used as a temporary residential facility for an intensive evaluation of children seen in the child guidance service.

And within the child guidance service itself there was need for many departures from conventional practices. Since only one psychiatrist and one psychiatric social worker serve the medical center, treatment cannot always be handled on a collaborative basis. With the absence in the community of both child and family service agencies the social worker sometimes found it necessary to assume such functions. Situations

were also encountered where both parent and child were so disturbed that simultaneous treatment might need to be attempted by the psychiatrist. Unconventionally also people came for help who would ordinarily be referred elsewhere—friends, neighbors and associates. To turn them away might have meant a total denial of help. This imposed a special burden on us, but it was the reality and would be characteristic of any such similar program in a rural area where a small group of specialists attempts to meet all mental health needs.

We have several times referred to the charge on us to meet the mental health needs of our community as part of a comprehensive program of medical care. It is perhaps less presumptuous to state that we were aware from the beginning that we could not do this alone. We did begin by offering a core of treatment services to adults and children within the medical center and in the child guidance service. Out of the response to these services, we were able to assess more realistically the community's needs for education and for broader programs designed to define and combat incipient emotional problems. In making the skills of our team available in a broad sense we have been able to encompass some treatment, some education both to impart a better understanding of mental health concepts and to awaken knowledge of potentially pathological situations, and some preventive activities in the form of anticipatory guidance with parents and school personnel both. In all of these activities the professional team has had the function of constantly identifying forces in family or community inimical or supportive to sound personality growth.

To implement such a comprehensive program, however, there is always the need for community support and understanding of the aims and objectives of the professional.



Hunterdon County now has a Mental Health Association, but only after several years of intensive planning and activity by the mental health team in conjunction with a mental health committee of the board of trustees of the medical center. Hopefully this association will become the community arm of the mental health services of the medical center and the medium through which the concerns of the professional staff around the prevention and treatment of emotional problems may be transmuted into a community program which will provide an optimum setting for sound personality development. The association will also be in a position to rally tangible support for mental health services in the future.

In presenting our program and our problems it is important to emphasize that we did not extend or modify our functions haphazardly. Our program represents a purposeful adaptation to an existing set of conditions. Child guidance services can maintain a meaningful existence only in a favorable milieu. Our service has had to

be unconventional at times and has had to move into numerous byways of community activity. That it has been augmented in its functions by a pediatrician and nurse consultant on the one hand and by the supporting arm of the Mental Health Association on the other is most rewarding.

In sharing our experiences, we should emphasize one final point. Communities such as ours need personnel whose orientation goes beyond concern with the intrapsychic processes of the patient and his family. It should not be inferred that rural communities have fewer pathological situations requiring careful and skillful therapeutic measures. The psychiatrist is here, as everywhere, under pressures to treat seriously disturbed patients, but when his sights are on a broad mental health program for a community he must be willing to devote considerable effort to the development of other resources for prevention and education, so that the treatment he extends is not handicapped by an unfavorable social climate.

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DAVID HALLOWITZ

ALBERT V. CUTTER, M.D.

# The pre-intake phase

## The beginning of the intake process

In a child guidance clinic, telephone contact, prior to the face-to-face interview with the parents, constitutes the very beginning of the intake process. This important phase of intake practice was opened up for further consideration by Paul Widem's article, "The Telephone Intake Interview in a Child Guidance Clinic."<sup>1</sup> Discussing the telephone interview's "value, limitations and dynamics," Widem shows how the case-worker sensitively and skillfully begins to help the parent at this early point with his or her uncertainty, anxiety, confusion and feeling of guilt. These are some of the major dynamic elements he presented: the worker "conveys through tone of voice his interest in the client's problem and wish to support the parent"; he provides reassurance by wishing "to know a few facts about the problem in order to determine

whether the clinic can be of help"; and he "offers immediate service to critical cases."

There is need to build up Widem's important contribution by examining in more detail the exploratory and helping aspects of the pre-intake phase, which may consist of one or more telephone conversations with the parents. The thinking and practice intensively developed by the Guidance Center of Buffalo over the last three years may be a step in this direction.

In our clinic's history—and this may be true also of many other child guidance clinics—the office secretary routinely used to schedule intake interviews, getting only

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Mr. Hallowitz is the assistant director and chief psychiatric social worker and Dr. Cutter the medical director of the Guidance Center of Buffalo.

<sup>1</sup> *Social Casework*, 38(November 1957), 485-89.

the briefest description of the youngster's difficulty. Five years ago this became a professional responsibility. Even so, however, the amount of information gathered on the phone, and the dynamically helpful responses to the parents' feelings, were brief and minimal on the assumption that a face-to-face intake interview was an essential first step to becoming involved in a case. Referral to other helping resources was done at the point of the initial phone conversation only in very clear-cut instances of a case not being appropriate for the clinic.

About three years ago, the pressure of the large number of intake interviews and the ever-growing waiting list compelled a more extensive use of the initial telephone contact. We had been finding that time-consuming intake interviews often resulted in referral of cases to family and child care agencies; and that cases already in diagnostic evaluation and treatment were more suitable for these agencies. Could we use the pre-intake phase more effectively for screening purposes, we asked ourselves?

As we proceeded to explore this, we found that we were being of more immediate help in referring cases to other community resources. A 1957 survey revealed that 32 referrals were made to family agencies during the pre-intake phase, as compared to 110 cases accepted for clinic services—22½% of the total of these cases. We found also, in our pre-intake work, that we were getting a fuller picture of the problems in a case, which was useful in the face-to-face intake interviews; and that the relationship between the clinic and parents was, in a beginning sense, being formed.

Let us now turn to the dynamics, process and specific content of the pre-intake phase.

The fact that a parent calls the clinic does not always mean he has made a clear decision to seek help. Parents' attitudes in this

regard can vary from an urgent unconflicted wish for help, to ambivalence, to toying with the idea, and to being almost opposed (as may happen in authoritative referrals). In any event—but more so when parental decision to seek help is marked by conflict and uncertainty—the parent subconsciously assesses the worker's attitude, as conveyed through his responses, and its effects upon the parent's own feelings. For example, in a given situation, the worker might play down the problems presented by the mother because he failed to sense fully the covered-up parental anxiety, or because he wanted to be reassuring and supportive, or because he honestly felt that no real problem existed, and so forth. Even though the mother herself might have tended to minimize the problems, the worker's doing so—for whatever reason—may well give her a negative set to the clinic and may dam back her seeking help.

The showing of honest-to-goodness understanding of the parent's distress is done through dealing empathically with the feelings detected in the phone conversation, maintaining objectivity as well. For example, the parent might express grave doubt about the clinic's ability to be helpful, or negative feelings toward psychiatrists or clinics or toward professionals in general. The worker expresses his understanding that the parent has mixed feelings about seeking help and has some fears about this as well. He encourages the parents to come in for a talk with one of the staff members about the problems troubling them.

The foregoing indicates the importance of handling telephone contacts in a clinical way. The telephone interview is not merely a medium for fact-gathering. It is a medium also for showing real understanding and acceptance of the parents with problems of their own as well as with the problems that pertain to their child.



Because the telephone contact has this important clinical aspect, the general principles of face-to-face interviewing are applicable.

As the parent expresses herself about the child's problems, the worker gets a beginning symptomatic picture. He also gains a beginning awareness of parental feeling about this, not only from what the parent actually says, but on a non-verbal level too. It is often possible, for example, to detect whether the parent is at ease, hostile, anxious, bewildered, confused, fearful, withdrawn or depressed. It is necessary for the worker "to be where the parent is." That is, if the worker can feel with the parent, he will be able comfortably to convey respect for and understanding of her, and help her to reveal more freely her dilemma.

In this context of empathic feeling, if the worker does not understand the problem as presented, he can say so and feel secure that the parent will not be offended but will try to clarify it. The distraught parent may seek direct answers to questions. The worker must be free to admit that not knowing more about the situation, he cannot with honesty answer the question. The admission of "I don't really know" can be an important dynamic.

Silence on the other end of the phone may be handled with an empathic comment such as "This problem has been most upsetting to you" or "It is most difficult for you to talk about this problem" or "It really was difficult for you to call." Such a comment shows understanding of the embarrassment or fears or worries which the parent has in calling and coming finally to a starting grip with the problem. Also, it may release a flood of feeling, and with this an ability to talk further about the problem.

It may be important to identify with the parent and the effect of the problem on the parent. For example, an appropriate "I

know just how you felt" or "I don't blame you for feeling that way" or "I see what you mean" may also allow for further expression of feelings about the child or about other members of the family.

In other words, the sensitivity and skills of the worker are qualitatively the same in the pre-intake phase as they are in the face-to-face interview. The difference lies only in the amount, kind and depth of content.

The helping process begins at the very moment the parent picks up the phone to call the clinic. Thus, the receptionist-telephone operator—whose manner must be friendly—has an important responsibility. If the intake worker is not readily available, the receptionist asks for the parent's name and phone number, gives her in turn the name of the intake worker, and assures her that he will call her back soon, or at least that day. If the anxious parent has need to "spill" to the receptionist, the latter assures her further that the worker will go into this in detail. The receptionist leaves a message for the worker, including any content the parent has imparted.

The worker's initial telephone conversation with the parent lasts about 15 minutes. It is usually the mother who calls, but sometimes fathers take the initiative. After greeting the mother and giving his own name, the worker will say in effect: "I understand you are having a problem with your youngster." Even though the worker in some instances may already have a fair amount of information about the case from the referring source, he will merely refer to this and ask the parent herself to tell him about her concerns.

The first problem mentioned has special significance because it often means—not always, of course—that this is uppermost in the mind of the parent for which help is being sought. For example, the school

referred a youngster primarily because of stuttering but the mother did not mention this in her opening remarks. She was more concerned about his being high-strung and nervous. The subsequent intake interview bore out the fact that the parents had only secondary concern about the symptom of stuttering.

In an effort to gain a well-rounded picture of the child's problems, and of the environmental circumstances impinging upon them, the worker helps the parent to enlarge upon the specific problems she first presents and to consider other possibilities. As discussed above, the worker's warm interest, gentleness of approach, sensitive empathic and supportive responses must be inherent throughout the telephone conversation.

In developing a full symptom picture on the phone, the worker—mostly in the context of what the mother is saying but sometimes directly too—asks such questions as "How is your youngster getting along in school?" "Is there any question about his basic intelligence and ability to learn?" "How are his relationships with other children in his class?" "With his teachers?" "How does he get along in the family?" "With father?" "With mother?" "With brothers and sisters?" "Does he wet the bed?" "Bite his fingernails?" "Suck his thumb?" "Does he have such other nervous mannerisms as eye-blinking and facial twitches?" "Does he have friends and playmates in the neighborhood?" "Are there any outstanding physical or medical problems?" The worker will ask specific questions about gross and fine coordination, hyperactivity, and—in rare instances when the symptom picture leads up to it—blank spells and convulsions. This is especially true when the parent gives clues about the possibility of mental retardation or brain damage.

While talking about the child, the mother may already have given the worker some information about the family situation. She may have volunteered, for example, that the child does not have a father owing to death or divorce; that there are one or more relatives living in the home; that both parents are working, spending little time with the children and leaving them unsupervised most of the day; and so forth. The worker can then use what the parent has already related to help her enlarge upon the family picture. If the parent has not as yet told anything about the family, the worker can ask: "Is there any problem within the family that might have a bearing upon the child's difficulties?" The parent usually brings out that which is significant. Often, too, the parent will interpret the question in part to pertain to the marital relationship. A direct question about the marital relationship also can be fruitful. The mother may say that she and her husband get along well together. From the subtle qualities with which this is said, the worker might be able to discern whether this is a guarded or frank response. On the other hand, the mother may say that there has been much conflict between the two. If there has been a history of separation, the mother may then bring this out as well. The worker also inquires about the father's interest in getting help—if it is the mother who calls—and the response gives further indication about the quality of the marital relationship.

It is to be noted that the worker does not ask the parent about her ideas of causation, nor encourage her to express herself in this regard. This gets into deeper psychodynamics and requires much more time than that allowed by the limits of the telephone conversation. Moreover, the deep, complex and subtle conflicts and feelings in the parent-child and inter-parent relation-

ship can more effectively be handled in the face-to-face intake interview, and in on-going work with both parents.

The worker asks about possible previous contacts with other clinics or agencies. Depending upon the nature of the previous agency contact, the worker might help the parent return to that particular agency. Such a routine inquiry at the point of the initial telephone contact can save the clinic and the family much valuable time.

Usually parents readily understand and accept our need for school, medical and other reports and give their consent to our writing for them. If the parent hesitates, the worker expresses awareness that she has some doubts or misgivings about this. She will then bring out her feelings and these are discussed mostly in an interpretive way. If the worker senses that the mother's feelings are not resolved, he will tell her that we will forego sending for reports and suggest that this can be discussed more fully when the parents come to the clinic for their first appointment.

For example, a mother was opposed to our sending for a school report because she was afraid that the contact with the clinic would become known to the teachers and pupils. In addition, she wished us to form our own conclusions about the child's learning difficulties and not be prejudiced by the school's psychological test findings. The worker explained that in our experience schools handle such matters responsibly and confidentially and that our diagnostic evaluation would not be influenced by the previous work done. The mother reluctantly said, "If you feel you have to, then go ahead." The worker replied, "I see that you really would prefer our not getting in touch with the school and I surely understand your feelings. I won't send for this report, but let's talk it over further when you come in."

As the phone conversation nears an end, the worker thinks differentially about several possible courses of planning.

1. If it appears that the case is possibly but not clearly for the clinic, the worker may feel the need for collateral information from the school, physician and other social agencies before arriving at a decision for an intake interview. He will then talk this over with the parent and come to the understanding that he will be in touch with her after receiving these reports.

Similarly, the worker may wish to consult with the medical director and will explain this to the parent as well.

2. In complex situations where the worker has consulted with the medical director, he may explain in a second telephone conversation the need for preliminary studies beyond the clinic before planning for the intake interview. He will then actively help the parent become connected with the particular community resources at which the studies will be done. When certain kinds of symptoms are present, perhaps a complete neurological work-up is necessary as a preliminary measure.

For example, in one case it was apparent both from the initial telephone conversation with the mother and from the reports received from the family physician and the school psychologist, that a neurological study should be done. Without arranging an intake appointment, but with the permission of the mother, the medical director and the worker conferred with the family physician and the school psychologist. We were all agreed upon the necessity for neurological study. This was done and it was found that the child had a brain tumor, which was successfully handled through surgery.



3. In less complex cases, the worker can independently recommend a preliminary study before planning to see the parents in an intake interview.

In one instance, a mother was quite upset and anxious about the fact that her son began to lose his balance and fall backwards. Because the child was also emotionally upset, she thought the most recent symptom to be emotionally determined. Asked if she had gone to her physician with this problem, she replied that she had not. The worker therefore suggested that she do so without delay and then, with the physician's help, we could determine whether or not our services were needed. The mother reported back later that she had gone to her physician and that he had found a physical basis for the symptom and was effectively treating it medically. The child's emotional upset cleared up also.

In another instance, where stuttering was the only presenting problem, the worker recommended a speech evaluation to determine if the problem had an emotional or a physiological origin. The report subsequently received stated that the child was in need of our clinic's services. The parents were then seen for intake interviews. In other situations involving stuttering, speech therapy instead of psychotherapy was recommended.

In a third instance, the only problem evident in the full telephone conversation with the mother was that her daughter was not progressing well academically. To the mother's knowledge, the school had not done any psychological testing. Believing that the school had a responsibility to check into this further, the worker arranged for the school psychologist to see the child. The latter found definite intellectual limitations, and on the basis of this finding the school changed its educational approach. A follow-up telephone conversa-

tion with the mother revealed that the foregoing was discussed with and accepted by the parents. A second follow-up telephone contact three months later showed that the child was doing better and that the parents were satisfied with the school program for her.

4. In certain kinds of cases it is occasionally possible to omit the step of a separate intake interview with the parents, and to schedule this to coincide with the child's first appointment for diagnostic evaluation. This occurs when the symptom picture obtained on the telephone is almost entirely in the realm of possible mental retardation, organic brain damage or other unusual physical and medical factors. If there is an emotional problem, it probably stems from parental confusion and lack of understanding about such factors. Consequently, to be able to help them, it is essential first to work out a differential diagnosis of the child through psychological and psychiatric examinations. The emphasis in the telephone contact would be upon getting the symptom picture, learning fully about previous studies and getting permission to obtain reports of these studies. For example, the pediatrician and parents of a 3-year-old girl wished our help in making a differential diagnosis with respect to symptoms of cerebral palsy, mental retardation and emotional disturbance.

5. There is one group of cases in which it is difficult to determine whether the services of a child guidance clinic or of a family agency are needed. These are the cases in which there are major family problems of a kind that ordinarily are appropriate for a family agency but in which the child is presenting symptoms of emotional disturbance.

It is possible to formulate only general

criteria which have to be applied flexibly to each individual case.

If the child seems to be quite disturbed emotionally despite major family problems we will at the very least explore the situation further through an intake phase and a diagnostic evaluation of the child and the family. A mother once told the worker only about the problem of poor school adjustment. In response to his further inquiry she revealed that her daughter had tics and nightmares and walked in her sleep. The surrounding familial circumstances might have prompted the worker to suggest a family agency, but upon learning that the child's symptoms indicated a probable deeper disturbance than the single symptom of poor school adjustment would lead one to believe, he planned with the mother for an intake interview.

On the other hand, if the child's symptoms and problems seem to be a direct outgrowth of severe social pathology within the family and if the symptoms and problems do not indicate severe psychopathology within the child, we refer the case at the point of the initial intake inquiry to a family agency. Some factors in the family suggestive of referral to a family agency are repeated separations between the parents, general family disorganization, previous break-ups of the family with placement of the children, numerous moves by the family from one community to another, both parents working and several relatives living in the home, more than one child showing signs of disturbance, and the parents having recently married each other following previous marriages, with the child apparently reacting to the new situation.

The working relationship between the two agencies should be such that, through conferring, the family agency should have the freedom to refer the case back to us or to suggest a cooperative treatment plan.

### CASE ILLUSTRATION

In an anxious and excitable manner, Mrs. K related that since coming to Buffalo a year ago her 11-year-old boy has threatened to be "bad until we move back to Detroit." David evidently is attached to his grandmother in that city. He talks back, is very fresh, has been getting into sex play with his sister, and has kicked his sister. In school he does not sit still and his performance is erratic. Sometimes he will get zeros and other times he will get 100. He has kicked his teacher and has fought with other boys. He does not have any friends in the neighborhood or in school.

I asked if the parents had had worries about David when the family lived in Detroit. "Yes," she replied dejectedly, "for many years. I guess we should have done something about it long ago." I said I realized how difficult it is for parents to seek special help. As though this struck a responsive chord, Mrs. K went on to say that she had hoped David would grow out of it.

I asked about other possible symptoms of disturbance, mentioning them specifically. The mother replied that none of these applied to David—except that he wet the bed until he was 6, but the physician had said this might have been due to a sugar condition.

I wondered if there are any problems within the family to which David might be reacting. The mother then told me that she and her husband were separated for three years but came together again about a year and a half before her call to us. With troubled rather than angry feeling, she went on to say that the father beats the boy severely, leaving black and blue marks on him. He will punish the boy also by having him sit still for long stretches of time. He does the same to all the children.

The mother has found that there is no one trying to tell her husband how better to handle the children because he does not listen to her. Now, again, she asserted he has a terrible temper and a very mean disposition. I said that I can see how angry and upset she feels. After she expressed further her upset feelings about her husband, I commented that evidently they do not get along well with each other. The mother stated that this is true in some respects, but not in all. In response to my question, the mother replied that her husband is interested in some help being obtained for the boy but does not have too much conviction about this as yet. I said it would be natural if she too had some doubt about this.

I talked with the mother about applying to the family agency, explaining that it seems as if the entire family needs help. She then told me she had tried to reach this agency before calling us but could not get through on the telephone. I gave her more specific instructions, mentioning specifically the name of the intake supervisor. I suggested further that she call me again if necessary. She expressed appreciation for my help.

Follow-up telephone contact with Mrs. K a week later revealed that she was able to obtain an intake appointment at the family agency.

In making a referral to a family agency, the importance of followup must be emphasized. In our community it has been found that a large proportion of inter-agency referrals, carefully worked out on the basis of direct interviews, do not reach fruition.<sup>2</sup> This could be equally true—if not more so—for telephone referrals.

We telephoned the parent after a week has elapsed to ask if she has followed through on our recommendation. If not, this will be discussed further with her in the future, and if necessary the parents will be invited to come in for an interview to discuss with us the entire situation. Several times this follow-up procedure has resulted in consummation of the referral.

Another function to keep in mind is that of informing the person who referred the case to us about our helping the parent get to another agency. This has value not only from the standpoint of good community relations, but as an additional safeguard. A school principal, for example, subsequently informed the worker that a mother was disappointed and angry about not getting service at our clinic and decided not to go to the family agency recommended. Thereupon the worker called the mother and arranged an interview for the parents, in which they were helped to work out their feelings about the referral and accept it.

6. In the majority of instances of course, it is clearly indicated that the child and the parents may well need clinic help and consequently an intake appointment is arranged.

## CASE ILLUSTRATION

Mrs. F at once asked if Dr. J had called me about her 10-year-old daughter. I said he had and asked if the mother herself would tell me about the problems with Betty. In a halting and restrained manner, as if trying to keep from crying, Mrs. F told about Betty stealing money, candy and small articles at home and from stores. Three months ago she had confessed to her parents about all of this. The confession had been precipitated by her hearing in school about a theft of \$25. Following this confession, there had been "a complete change

<sup>2</sup> "The Buffalo Self-Study: A Special Study Project of the Council of Social Agencies," 1957.



of personality." Previously, she had been nervous and since that time she hasn't had any more attacks. The mother could hardly stand her crying and was almost in tears. I said that Mrs. F. is feeling very badly at about the best of things. She is very sad for not being able to control herself. I assured her that I know she could not help crying because she does feel very upset and unhappy. Apparently more at ease after the release of feeling, Mrs. F. went on to say that Betty has become very apologetic about some of her things, for example, the breaking of a toy. There has been no recurrence of the stealing since the confession.

I asked how Betty is getting along in school. Mrs. F. replied that she does average or below-average work. Now in the fifth grade, she functions on about a fourth grade level. She has particular difficulty with reading. Betty gets along "well enough" with the other children in school and in the neighborhood. Asked about Betty's relationship with the children in the family, the mother related that there is no unusual difficulty with her 13- and 6-year-old brothers. She "loves very much" her baby sister, now a year old.

I inquired specifically about other symptoms. Betty wet the bed until two years ago and has wet occasionally since then. She does not suck her thumb or bite her nails. Spontaneously the mother added that she rocks every night before going to sleep. Mrs. F. went on to say that on and off for several years Betty has had spells of eye-twitching. They last for a week. The last occurrence of this kind of prolonged eye-twitching was about two months ago. At the present time, there is occasional and momentary eye-twitching. The eye doctor could find nothing wrong when he examined her for this condition.

I wondered if there is any problem in the family which might be upsetting Betty.

Mrs. F. then stated that her father's death at a fairly early age has been a very heavy great loss. The family life suffers as a result. When home, he seems to take more interest in the other children than he does in Betty. He has left most of the responsibility for Betty's difficulties to her. The mother paused and then stated purposely restrained words. Mrs. F. went on to say that she and her husband have not been getting along too well together and there was a brief separation three years ago. There has been some improvement in these relationships since then. The mother concluded further that at the time of the separation three years ago she had "a nervous breakdown" and was under the care of a psychiatrist for seven months. Now she sees the psychiatrist every once in a while. I remarked that Mrs. F. seems to have had a hard time. She expressed herself a little more on her distress at that time.

I asked if it would be all right with her if I wrote to her psychiatrist for a report. When she was asked whether this was necessary, I explained that it would be up to her to have more understanding of her but assured her that if she really did not wish me to communicate with her psychiatrist, it would be perfectly O.K. Mrs. F. unresistively gave her consent.

I asked if there had been any previous contact with other agencies in the community. She replied that they had not been to a child guidance clinic, but she and her husband had gone to a family agency four years before. They seemed to be making some progress but then her husband withdrew and she saw no value in continuing herself.

The mother gave me permission to obtain reports from the school, the pediatrician, the eye doctor and the family agency.

An intake appointment was arranged for both parents.

The pre-intake phase is not completed until the parents actually appear at the clinic for the intake interview.

The mother may call to cancel the appointment because of illness or other reality factors. The worker expresses sympathetic understanding and arranges another appointment. The same occurs when the parents fail the first appointment without informing the clinic beforehand, except that the worker takes the initiative in calling her. If there is a recurrence of a cancelled or failed appointment—again presumably because of reality factors—the worker may feel that the explanation is genuine and accept it at face value. However, if he senses parental difficulty in taking the step of actually coming to the clinic, he will empathically comment upon this. Usually the parent is thereby enabled to bring out the feelings that bother her—for example, "My husband is still not in agreement with me about getting help" or "Maybe we are making too much out of it" or "Will people think that by coming to the Guidance Center it means that my boy is crazy?" and so forth.

Feelings of this kind, of course, can be expressed at any point during the pre-intake phase. In the spirit of trying to understand the parent's feelings, the worker helps her to express them further. He verbalizes his acceptance of the parent's feelings, answers specific questions interpretively, gives his honest opinion about the child and parents being in need of clinic help, and suggests that mother and father think it over some more. If the parental decision at that point or later on is not to come to the clinic, the worker again expresses his understanding and acceptance, and assures them that they can get in touch with us at any time in the future should they feel the need to do so. Often this representation of the clinic's consistent interest and willingness

to be of help results in the parents, now or later, coming for the intake interview.

One can readily see the value of the entry of the telephone interview in the record of this case, and of the reports to be received, in preparing the worker for the intake interview or interviews with the parents. He will have in mind the various specific symptoms so that he can obtain a fuller picture of them, and ask when they first arose. Within this context, the developmental and medical history can be obtained. It may become possible to make connections between significant events and developments on the one hand, and the onset of particular symptoms on the other. For example, what was the effect on the boy of the trouble and upset between the parents? Similarly, the effect on him of the newest child's arrival? The intake worker will have the benefit of the psychiatrist's report on the mother and will now want to begin to assess her present state of emotional health, her ego strengths, and so forth. Problems in the parent-child and inter-parent relationship will need to be explored—toward helping them become aware of and understand their part in the child's difficulties.

In summary, we have seen that the pre-intake phase is a delicate and complex part of the intake process. Sensitively recognizing and empathizing with the parents' feelings about seeking help and about the child's problems besetting them, the worker develops a well-routined picture of these problems and of the social situation. The worker's approach is a clinical one in gathering and evaluating information and in conveying real understanding and acceptance of the parents. The authors have shown the principal similarities and the essential difference between the work with the parents through the medium of the telephone and that done in face-to-face in-

terviews. On the basis of a well-rounded picture of the child's symptoms and of the problem areas, the worker thinks differentially about alternative courses of help. In this, he functions as a member of the clinic team, consulting, when necessary, with the supervisor, medical director or other members of the staff. Preliminary studies prior to the arrangement of intake interviews are sometimes recommended, and help is given the parent in having them done.

The authors have presented the criteria for making early referrals to family agencies; the process of helping the parents be-

come connected with such agency; and the importance of follow-up procedures. Although regarded primarily as helpful planning for families, early referrals also bring about economies for the clinic in substantial saving of staff time and ultimately in a smaller and more manageable waiting list. Set forth also were the values of the material gathered during the pre-intake phase in preparing for intake interviews. The pre-intake phase is both the beginning and the bridge for deeper involvement of the parents through the ongoing intake process.



# Perpetuation of non-value

The professions of psychoanalyst, psychotherapist, case worker and counselor are built upon certain values, among which are a commitment to the fullest self-realization of a patient or client.

The role of value conflicts as a source of pathology and the place of value in personality formation and in psychotherapy have been receiving increasing attention in recent literature. The concept of "value" as it applies to therapist has not been so popular. Perhaps as an outgrowth of attempts to divorce itself from its religious and philosophical heritage, early American therapeutic psychology in general built up an aversion to the topic. Even today it is not

an easy subject for clinical discussions. Often this vital area has been covered with two glib assumptions or pronouncements—hands off the patient's value system, and the therapist should strictly avoid exposing his own. Both are impossibilities and it is wiser that the therapist be alert to what is transpiring within himself and within the client. The total approach to counseling and psychotherapy—the perceiving, selecting, collecting, organizing and interpreting of data—is a function of value systems.

This treatise does not purport to deal adequately with the question of value itself, much less to analyze all concepts of values or systems of values. But along with Plato, Kant, Kohler and many modern psychotherapists it takes the position that at the bottom of all human activities are certain values, "intrinsic requiredness or wrong-

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Dr. Rutledge is leader of the counseling service and the training program in counseling and psychotherapy of the Merrill-Palmer School, Detroit.

ness," the conviction that some things, in certain contexts at least, "ought to be" and others not. Insight is *all* awareness of such intellectual, moral or aesthetic value. Therefore, value and corresponding insight are the essence of mental life.

Whatever the system of thought, whether scientific or philosophical, as a part of its development there is a tendency to exclusivism whereby the values propounded by another system are denied. Although written several years ago, predating much of the recent rediscovery of value, Wolfgang Kohler's *The Place of Value in a World of Fact*<sup>1</sup> is still worth quoting:

"Scientists will insist upon 'objective procedure,' on 'careful verification,' or on 'genuinely scientific theory,' perhaps on 'the principle of parsimony' and on 'consistency.' Besides they will courageously defend freedom of thought, of research and of speech. Implicitly all this is accepted as valuable, as required. But the very next moment they will express their contempt of 'metaphysical speculations such as concern for ethics,' which 'cannot be submitted to the absolutely indispensable experimental test.' One begins to wonder whether logic would also have to pass this indispensable test—which is itself full of logical premises. Certainly in science we are not very clear about requiredness although our work is utterly imbued with it."

» Inherent in much professional training has been the concept that to be effective the psychotherapist must be secure apart from, and be inwardly free of, the authoritarian values attributed to the conventional requirements of the culture. At times this has been misconstrued to say that he should have no evaluational goals while dealing with a patient. At best it is a long route from the fairly fixed value systems of the therapist's youth to a state of "inner in-

dependence" of these authoritarian, culturally determined "things that ought to be." It is a still longer route to the development of an autonomous value system or philosophy of life for the therapist as a person. Many get lost, or live out a good part of their professional careers in the no man's land between outmoded and discarded value systems of the past and the emergence of a new meaningfulness that makes life a thrilling adventure.

It is this process of constantly exposing a budding philosophy of life to culture in general and to differing systems of value in particular which sharpens the perception of the developing psychotherapist, enabling him to deal helpfully with the values, lack of values, hierarchy of values and communication of values in a variety of patients. But since what the therapist essentially is gets to the patient through the healing relationship, he may fail to help and even hinder many who are struggling to find a more meaningful philosophy of life. He cannot lead them farther than he himself has traveled. In fact, unknowingly, he may help to perpetuate in the patient a system of "no value," or absence of value. This leaves the patient with an even greater divergence between what he has grown up to expect of himself and what he is. The patient may be less anxious for a while because of the beginning of new expectations of himself, but the risk is that he levels off in development where the least is expected without adequate new goals to direct his development and creative functioning. There is in man a remarkable tendency to be soothed and satisfied whenever a problem, instead of being solved, has merely been located somewhere.

<sup>1</sup> New York, Liveright Publishing Corporation, 1938, p. 36.

Kohler<sup>2</sup> came close to this position:

"When once born in the universities, the spirit of Nothing But does not remain confined to these institutions and to scientific books. Future teachers absorb this spirit in lectures and in reading. Afterwards they propagate the same spirit in high schools, both by what they say and by what they never mention. Enlightened writers do likewise when writing in newspapers and in magazines. Thus negativism spreads through a population like an epidemic. . . . Gradually Nothing But becomes the unformulated creed of your post-man, your politician and your prime-minister."

He went on to say that as this stage is reached people are void of any stable convictions beyond immediate personal interests. No principle is worth defending, because, after all, "What is a principle?" Without any conviction at all nobody can be expected to live courageously.

At the risk of being misunderstood, and of overdramatizing, the following may demonstrate what, for lack of more descriptive symbols, can be thought of as perpetuation of "non-value" which has reached serious proportions in clinical circles from the standpoint of patient and therapist alike.

Since the psychoanalyst is the parent figure to many of the clinical disciplines—including psychiatry, much of clinical and counseling psychology, social work, marriage counseling and pastoral counseling—he is a good beginning place. For the sake of

argument, take an analyst who has become relatively free of inner constraint by authoritarian expectations out of the past or present. He may or may not have attained a healthy, positive philosophy of living which makes his life creatively contagious. Perhaps he is developing such a new system of values but, being unsure of its effectiveness and desiring to protect them from his own value system, he divorces this quite successfully from his relationship to the patient or analysand.

Suppose the analysand is a young psychiatrist<sup>3</sup> who needs help in resolving a neurosis or wants an analysis as part of his preparation as a psychotherapist. The analyst joins him in a cooperative effort to understand himself well, including his innermost needs and motivations. Really, the process began long ago. In college he began to reject parts of the parental and community value system, although suffering pangs of guilt along the way. So painful did the struggle become in medical school that the basic conflict between values was repressed. A new value system with generations of tradition and all of modern medical science as its supporters was substituted. A system of treating illnesses was developed in which the doctor became the authority, thus usurping for himself the authoritarian role which he had resisted in others in his development. The needs of people keep crashing into this mechanical system, but, to keep old needs of his own from being reactivated, he becomes calloused and even bitter against the value system which the patient won't give up for that proffered by the physician. This, along with exposure to psychosomatic literature and a gnawing hunger to understand and be comfortable with himself, leads him to specialize in psychiatry. Here again he is caught in a struggle between the authoritarian, organically based medical

<sup>2</sup> *Op. cit.*, p. 32, in quoting his friend about the "scientific" contention that moral convictions and other values are a mere by-product of historical circumstances; that they are mere facts not transcended by value as a principle in itself.

<sup>3</sup> The dynamics would be only slightly different were he a psychologist or some other clinically trained professional person.



training and the theory of psychogenic origin of certain illnesses.

Let's say that the same discomforts as outlined above lead him to undertake a psychoanalysis. It is natural that the analysis should lay bare his early development and conflicts, along with hangover, unresolved emotions and dated motivation. The repressed struggle over values is activated and in a tremendous effort at expurgation he drags forth his old values, discovers their meaning, analyzes them away and leaves them beside the couch. The psychoanalyst has participated in this with him, laying bare with a skillful psychic scalpel the self-protective mechanisms. Gradually the analysand begins to feel free of encumbering ties from the past.

This is a crucial stage. Repeatedly analyses can be seen ending at this point. He is a new person and is cagey about entanglements with new values which might prove as tyrannical as the old. The likelihood is that he has identified quite strongly with his analyst and, mistaking the "negative" analytic work for the analyst's way of life, is glad to level off with the attitudes he thinks the "old man" lives by. Another possibility is that if the mature analyst seeks to move the analysand on into consideration of a new philosophy of life, the growing psychiatrist feels threatened by those new limits and rebels against this stage of work, fleeing into the new-found safety of "the analyzed." Thus, in him, the establishment of a new way of life is characterized by "non-value." From the standpoint of the analyst, he may have gone no further himself and not know how to make the client aware of the need to proceed; he may assume that his role is to "take care of the analysis, leaving integration to occur spontaneously"; he may believe that the growth process will take care of

itself now that the blocking neurosis has been resolved.

All too often the new growth process is barely under way in the patient; the neurosis has been understood but not removed; and integration may occur all too quickly. Energy is expended in defending the new way of life which is characterized, if not by an absence of values, by the failure to deal openly with values and to develop a positive philosophy of life. Life becomes "Nothing But," in the words of Kohler, and a negatively oriented system of therapy becomes the one and only philosophy.

Feeling unable to relate to his family—who continue to adhere to the old values or who have been made miserable by his parroting of the analytic sessions—our psychiatrist may neglect them under the guise of his loyalty to the Hippocratic oath. In addition to what this does to the wife and children, it leaves him without the most valuable source of love and affection. Starved and drained dry by the demands of patients, he can become a victim of the "non-value" state. In most cases there is a good chance that life will teach him a thing or two, that in treating his patients he will treat himself and grow into a more mature and positively oriented person.

But professional life has not been standing still during this time. He has continued seeing patients in intensive psychotherapy and, if trying to qualify as a psychoanalyst, has been doing analysis under the control of his own analyst or another teaching analyst. Numbers of patients, many of them younger psychiatrists, psychologists and other counselors in training, have come under his care while he was his most "negative" self. It is only natural that the awareness of his own conflicts should help him spot similar ones in them, and the method of treatment likely will be closely akin to that being learned through his own

analysis. Because the treatment of his patients tends to be of shorter duration and therefore more directive than what he is experiencing, and because he tends to hide himself as a person, they get an even more "non-value" orientation than he. This can lead to basic rejection of *all* the old ways as associated with illness or immaturity, which, since there isn't time for thorough working through, quite often is accomplished by repression. What results may be more disturbing than living by any one system of values. The conflict between the repressed old and the new non-value system creates guilt and resultant tension. The tension is felt as a threat of recurrence of the old symptoms and the new way is propounded with a vengeance.

While the young professional person of whatever discipline is in therapy he is all the while working with patients who may in turn identify with the scientific, liberated "air" they feel about their therapist, mistaking what they don't know about him—or what he doesn't possess, or the vacuum in which he lives, or an immature level of development—for the real life to which they should aspire.

The tendency to identify with one's therapist or with the discipline he represents is reinforced by the hierarchy of inadequacy feelings found among psychotherapists and among average people, somewhat according to required years of therapeutic training. The parent feels inadequate in comparison to the teacher and minister, who in turn feel inadequate to the psychologist. The psychologist and social worker feel inadequate to and increasingly strive to be like the psychiatrist. The young psychiatrist strives to be like what he thinks an older psychiatrist or psychoanalyst is like. An occasional psychoanalyst feels inadequate to God.

Seriously, when this pattern prevails, and

each specialist, along with the next up the line, has a negative orientation to therapy and to life, a "non-value" system of values may be perpetuated from generation to generation of psychotherapists.

Clear-cut illustrations of the resultant confusion have been seen in several clergymen who underwent analysis whether for health or professional reasons. Many theological students who are preparing for pastoral counseling wisely seek intensive psychotherapy for themselves. Most of them turn to the young psychiatrist or analyst in training because they can afford only the smallest fees and his schedule will admit them. Usually they quickly discover that much of what they have believed is based upon magical, infantile projections and upon the compulsions to conformity exerted by the family and by the local church. Therapy threatens to destroy their whole way of life, including the career for which they have spent years in preparation. Some terminate therapy prematurely, while others try to maintain both a "new" and an "old," a "scientific" and a "religious" orientation. Others change professions. Fortunate indeed is the one who finds a therapist who will not settle for blanket rejection of the old faith or way of life, but encourages the discovery of principles which apply in all phases of life.

A medical man, Dr. A, who came for marriage counseling, is a case in point. He had been married 13 years and had three healthy children. He was a top man in his specialty and in the social directory. He was sick of marriage and parenthood, and felt medical practice had little to offer and life not much more. He felt alone and yet couldn't accept friendly advances from either men or women. He blamed medical practice and his wife for the loss of all the real friends he felt were his before marriage. With much exploration he came to see that



his wife was not responsible and that he had merely used the caduceus to justify the hollow existence he had experienced. He clearly dated his "loss of faith" to his 2-year analysis and his resultant determination to live "an absolutely scientific life." At that time he had felt friends merely were opportunities toward whom to express possible homosexual wishes and love was "just sex." The inability to resolve possible latent homosexuality, and the subsequent fleeing from closeness to both sexes, along with rejection of his early rigid religious training, left him a lonely man indeed.

While working with Dr. A the therapist was discussing with an old physician, who had been in the city for years, a now famous and effective psychoanalyst, Dr. Z. The elderly physician said: "Just think—I remember when I stopped sending patients to Dr. Z. He had been a brilliant young psychiatrist but for about two years while he was completing his training analysis I stopped referring anyone to him. Without exception my patients got worse under his care."

Suddenly the therapist remembered that Dr. Z had analyzed Dr. A, the current patient. Out of curiosity, he asked if the old physician could date the years when Dr. Z was seriously upsetting his patients. He could quite definitely. It was the same 2-year period during which he was analyzing Dr. A.

This illustration as stated without all the facts can be picked to pieces, but taken even partially at face value it illustrates the effect of perpetuating a "non-value" orientation to life.

Recently an outstanding psychoanalyst was discussing "the inability to give of oneself and to love within the therapeutic relationship" which often is camouflaged by insistence upon a position of pseudo-objectivity. He said: "For my original

analysis I chose one of the best trained analysts in the world. He knew his stuff, but what a cold fish! Later I realized that something serious had happened to me, or maybe it was something which had not happened. I reentered analysis, but this time with a mature, comfortable, loving, giving person. In this relationship I became what I am; there I learned to live and to love."

Again let it be said that this paper is an overdramatized picture to call attention to a professional malady. There are many major exceptions, as evidenced by recent formal discussions of value. A few psychoanalysts are philosophers in their own right, healthy ones at that. They are attacking this problem by stimulating trainees to a study of philosophy and other great literature, challenging them to a healthy self-fulfillment which will produce effective psychotherapists. Perhaps the second best corrective is calling to the attention of those therapists yet in training, and those currently practicing, the stunted state of development in which they may find themselves. The hope is that their personalities may be reopened to growth and that they in turn may challenge their trainees to a practice of psychotherapy which is concerned with the development of a meaningful, autonomous system of values, whether religiously or scientifically conceived, along with the elimination of outmoded and hindering codes which determine feeling and conduct. In the meantime, the practitioner can see to it that the patient has an equal opportunity to explore the value realm of life along with other areas. Perhaps the area of life felt to be most taboo today, whether in conversation with friend or therapist, is religious belief.

A therapist may realize that he cannot



deal objectively with such areas as value, religion and *Weltanschauung*, or that the therapeutic relationship is ending before the patient begins to grow a more positive way of life. At least he can see that the patient becomes aware of the therapist's interest in this part of his life. Sources of referral can be utilized, and the patient can be challenged to continue working at his growth after therapy is ended. The

average psychotherapist well might make greater use of the family life educator, the clergyman and other well-trained, mental health oriented resource people to continue stimulation of growth in the patient during and particularly subsequent to therapy. This would prevent the relapse of many patients and would encourage the translation of insight into a healthier life for self and for the family.

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WILLIAM L. PELTZ, M.D.

MARTIN GOLDBERG, M.D.

## A dynamic factor in group work with post-adolescents and its effects on the role of the leader

A program of modified group therapy, with 4th-year medical students as the members of the group, has been conducted during the last four years at the Medical School of the University of Pennsylvania and has been described elsewhere (9, 10). The group experience program is an adjunct to the regular program of 4th-year teaching in which the students conduct psychotherapy under close supervision with outpatients in the psychiatric clinic of a general hospital.

Most of the groups have been conducted on an elective basis, although the members of several have been assigned without being consulted beforehand. Each group develops its own goals and methods of procedure. The purpose of the program in general, however, has been defined as follows: "To have the members of the groups come to understand themselves and each other better

through experiencing and examining their reactions to one another and to the leaders. This experience aimed to help them develop awareness of their feelings, attitudes and mechanisms of defense. This gain in self-awareness would lead to greater objectivity, thus enabling them to understand and treat their patients more effectively."

Each group experience, as they are called, takes place once a week for 18 weeks.

Most of the members of these groups, being in their fourth year of medical school, were in their middle or late twenties. One might assume that, having passed well beyond the period of adolescence and of adolescent revolt against authority, the

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Dr. Peltz is an assistant professor of psychiatry and Dr. Goldberg an instructor in psychiatry at the University of Pennsylvania School of Medicine.

members would no longer be involved in a struggle for independence and that emancipation would have ceased to be an important or central concern and issue to them. Such, however, was not observed to be the case. In actuality, the relationship of the members to authority figures was the central or most significant dynamic factor in all of the groups in the program.

This possibly obvious finding has led the authors to a consideration of the process of emancipation of the individual personality. In our fairly complex society the transition from the dependent state of interpersonal relationships characteristic of infancy to the true interdependent state desirable in adult life is a long and often tenuous process. It is generally conceived that life proceeds through the absolute dependence of intra-uterine existence; the great relative dependence of infancy; the considerable dependence but emerging independence of childhood; to the conflictual period of marked struggle for greater independence characteristic of adolescence; and finally to the independence, or more properly, the interdependence of mature, adult life.

To get along successfully in our highly competitive society today many young people desire college, graduate and even post-graduate education. Hence, the state of dependency upon family often is prolonged considerably beyond the period of biological adolescence or chronological adolescence, the latter usually being thought of as corresponding roughly with the teen years. Whereas one might ordinarily think of maturity as following immediately upon adolescence, with one of its characteristics being a state of independence or at least freedom from excessive dependency, in actuality the process of emancipation is not resolved when the period of biological adolescence ends. Hence, it is suggested that following the period of adolescence in the

schema of the maturation and emancipation process we might think of a period which can be referred to as post-adolescence. Blos (3) has considered the subject of "prolonged adolescence," describing it as a pathological syndrome. Reserving the concept of prolonged adolescence for those clearly pathological situations such as Blos describes, we suggest that in our society post-adolescence is a normal phase in maturational development, particularly for males.

Maturity in terms of personality emancipation is reached when a person has sufficiently mastered his dependent needs to be able to effect a really meaningful end to the real and/or fantasy authoritarian relationship with parents and parental figures and replace it by a democratic, interdependent relationship with the assumption of full responsibilities.

It should be pointed out that the emancipation conflict exists on two levels: the struggle on the external level with parents, teachers and society and the struggle on the internal level which is fought within the individual against the still-persisting dependent needs (8).

Adolescents demand a greater degree of independence and more privileges than their parents feel they are ready to assume or than the parents are willing to give them. This is often because the parents feel that the young people have not yet shown sufficient evidences of assuming responsibility to warrant granting the desired privileges; at other times it is because parents cling to their children, not wanting them to grow up or become independent. In addition to this external struggle, however, adolescents experience an internal conflict in that they are struggling to grow up and free themselves from the strong dependency needs which they are still experiencing.

During post-adolescence the external and



internal conflicts are still going on but they have changed in form. The external struggle or revolt against restrictions and of seeking privileges no longer exists. The victory has been won in these respects. There are still external factors which lead to conflicts, however, for some post-adolescents. For example, some young people still have to depend on their parents for financial support; some may still have to live at home while working or obtaining graduate education and some may have taken on in-law problems.

The picture regarding the internal conflicts, too, has changed. The dependency needs are no longer as strong as they were during the teen years and the young person is now ready to develop more mature relationships with parents and other authority figures. With the lessening of dependency needs, the post-adolescent begins to relate himself to others in a manner that genuinely challenges autocratic structuring and presses toward a really equal relationship.

Reflections of feeling stemming from both the external and the internal conflicts of adolescents and post-adolescents are experienced in group work where they largely shape the relationship of the members to the group leader. In the groups of medical students on which this report is based the transference of unresolved oedipal feelings, the struggle for emancipation from old ties to authority figures, and the seeking of solutions through the finding of more mature relationships were observed. These were seen in the form of direct or indirect expressions of antagonistic feelings toward medical school, the faculty, various teaching programs in the school including the teaching of psychiatry, the group experience program and the leaders of the group itself. As has been noted in other groups (2, 4, 6),

members of the student groups tended to have their own expectations of the leader from the very beginning of the experience and also tended to fall into subgroups of "dependents" (those demanding openly that the leader gratify their needs) and "anti-dependents" (those protesting that the leadership was all wrong and could not possibly help the group).

In functioning as leaders, the authors allowed these post-adolescents complete freedom of expression, which eventually resulted in an open revolt against their authority, sparked by the "anti-dependents." This revolt was quickly followed, however, by the emergence of a state of interdependence and real group unity as more and more of the group members began to assume partial responsibility for the working leadership. It was the authors' impression that this emancipation from the leaders was the most significant experiential gain in the brief time of the group experience's duration. As others have pointed out (2, 4, 6), it appeared that the expression of hostility and revolt against the leader was a necessary and healthy aspect of the process of maturation within the groups, as it is within the lives of individuals.

It is generally accepted that group therapy (as well as individual therapy) should be conducted differently for adults and for children because of differing states of development and needs. Similarly, it is being suggested in this paper that because of certain differences in the maturation process, and therefore in emotional needs, group therapy requires a somewhat distinct approach in post-adolescents as opposed to adolescents.

In spite of their outward rebelliousness, adolescents still need their parents to set limits and restrictions and to satisfy their dependency; and in therapy they require

this similarly. The authors and others (1, 5, 11) have found in treating adolescents that some limits must be set and that the therapist cannot divest himself of all connotations of authority without risking a really chaotic situation. Permission and encouragement of growing independence and maturation are essential, but the therapist functions, consciously or unconsciously, as a kind, understanding and accepting parent. As such he is really a benign authority figure. In group therapy with adolescents the leader has much the same function and must still be very aware of the need to set limits. As Josselyn (7) has noted, "The adolescent looks for identity in the structure of his own age group but his own age group is as fluid as he is. It offers support to his ego, but it is, at best, a tottering, unstable brace." By maintaining his role as the good parent substitute, but always the leader, the therapist offers adolescents a new experience and one which permits identification, maturation and growth in the group. If the therapist should not assume these roles, the group experience could be nontherapeutic or even traumatic, since every member of an adolescent group has marked dependent needs and an absence or overthrow of the leader would result in an untimely and abrupt frustration of this dependency.

We believe that with groups of post-adolescents the rôle of the leader can and should be different. Although the leader will sense conflictual fantasies of himself as a parent-figure in the post-adolescents, he must recognize their readiness and need to emancipate themselves fully and to develop a new and more mature relationship with the leader and with authority figures in general.

Whereas in adolescent groups the anti-dependent revolt might prove to be devastating to the members if the leader did not

maintain control, the leader of groups of post-adolescents can and should permit this revolt to occur since the group is ready for it and can proceed to establish democratic interaction thereafter. In Foulkes' terminology (4), the leader can "let it happen. . . . He does not step down but lets the group in steps and stages bring him down to earth. The change which takes place is that from a leader of the group to a leader *in* the group. The group, in its turn, replaces the leader's authority with the authority of the group." When this last occurs, a mature relationship of interdependency within the group has been achieved. Most of the members have solved the external rebellious aspects of their adolescent struggle and have progressed sufficiently internally (with their dependent needs) so that they are not only able to resolve their own relationships to the leader on a fairly mature level but are also able to help the occasional rebellious member of the group to work through his problems. Hence, the leader can allow the efforts to displace him to proceed unhampered with full confidence in the group's ability to establish a democratic interdependence.

It is hoped that leaders of adolescent and post-adolescent groups will be better able to conduct their groups effectively if they keep these varying dynamics in mind.

#### SUMMARY

In 20 group experiences with medical students, who are in the post-adolescent stage of the maturation process, the relationship of the students to authority and authority figures was observed to be the most significant dynamic factor.

On the level of internal conflicts, post-adolescents are not struggling against dependency needs so much as adolescents are; and on the level of external conflicts they are no longer engaged in fighting parental

restrictions. Post-adolescents are evolving more mature relationships with authority figures on both internal and external levels. Reflections of feelings stemming from external and internal conflicts were observed in the group process. It is suggested that because of their differing levels of development and therefore differing needs post-adolescents in group therapy should be handled differently from adolescents. Leaders of adolescent groups, for example, when anti-dependent revolt occurs, must maintain a benevolent but appropriately firm authority role, while fostering ego-strength and development. Leaders of post-adolescent groups, on the other hand, should be more relaxed and permissive. They can and should permit such revolts to occur since they are mostly limited to a few members and will be handled by other members. Maturation with the development of interdependency will thereby be enhanced and the group experience will have been more meaningful.

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## Culture and mental disease

Since it has been proved that the frequency of mental diseases is generally in direct proportion to civilization and its accompanying social collisions, it might be surmised that these diseases are extremely rare on the Faroes, inasmuch as civilization has certainly not attained a high degree there, and the social collisions so agitating to the mind, under the patriarchal conditions which prevail, are proportionately very few. But on the contrary, there is hardly any other country, or indeed any metropolis, in which mental diseases are so frequent in proportion to the number of people as on the Faroes.—Peter Ludvig Panum, "Observations Made During the Epidemic of Measles on the Faroe Islands in the Year 1846."



## A low-cost psychotherapy program for Essex County, N. J.

This article describes the development by the Mental Health Association of Essex County, N. J., of an out-patient treatment facility for marginal-income families. This achievement was made possible through the cooperation of 32 psychotherapists, utilizing a multi-disciplinary approach.

Essex County, located in the north central region of New Jersey, has a population of a million people divided about equally between the Newark industrial area in the east and the wealthier suburban region in the west. Although there are sizable areas in need of urban redevelopment, the county

nevertheless ranks 11th in the nation in wealth with an estimated purchasing power of \$7,940 per family.

As impressive as these figures may appear, the number of requests for psychiatric assistance from families who cannot afford private care has increased each year as the educational programs and publicity emanating from our Mental Health Association have made them aware of their need for help. Our Essex County chapter has adopted the philosophy that community mental health education without mental health resources can lead only to an increase in anxiety among those recognizing that they have problems. The validity of our philosophy—and the dangers of denying it—became only too clear to our staff during the last two years when our referral and information department received more than

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At the time he wrote this paper Mr. Royfe was executive director of the Mental Health Association of Essex County, N. J. He is now director of programs and services for Big Brothers of America, with headquarters in Philadelphia.

1,400 requests for psychiatric assistance. The majority came from families in need of out-patient services and unable to afford private care.

The out-patient psychotherapeutic resources for adults in our community consisted of a traveling clinic, which made available 65 hours of treatment a week, and two general hospitals, both located in Newark, which made available an additional 23 hours of treatment to the residents in the area.<sup>1</sup> The caliber of services that these hard-pressed agencies offered to a patient varied from interviews lasting from five minutes to the traditional fifty minutes; similarly, the frequency of visits ranged from one interview a week to one interview in several months. The bleak fact that some clinics were encountering resistance from psychiatrists who were loathe to devote half-days to an operation which was frustrating and unrewarding further aggravated this desperate shortage of facilities.

The Mental Health Association of Essex County was deeply concerned with this overflowing demand and with the fact that patients had to wait many months for even these meager resources. We were further concerned because the caliber of care received by a person in psychotherapy was too often predicated on his ability to pay. Although many of the psychotherapists in the community spent considerable time in serving patients in marginal economic circumstances, the fact still remained that a disproportionate number of individuals in need of psychotherapy at a reduced fee were not obtaining the best possible services.

The Mental Health Association therefore decided to develop a program that would utilize the talents of competent psychotherapists in the community. In doing so, it sought to make the best possible use of their precious time, taking steps to assure through adequate screening that only those accessible

to out-patient psychotherapy and financially unable to afford the service would receive consideration. This low-cost psychotherapy plan, conceived as a demonstration project for a 3-year period, was designed to operate with a minimum expenditure of money, time, effort and building maintenance. Intrinsic in its philosophy was the fact that it aimed to give the highest quality of service to people within a certain income bracket, on a sliding scale in accordance with their ability to pay.

The plan was developed in conjunction with a group of psychiatrists, psychologists, and psychiatric social workers, and is under the chairmanship of a prominent psychiatrist residing in Essex County. Within the last year the plan has received the endorsement of the professional societies. Currently 15 psychiatrists and 17 psychologists are participating. Only the generosity of these professionals and their donation of time and effort have made this project feasible.

All applicants for out-patient psychotherapy are received in our Mental Health Association office and are directed to our psychiatric social worker. He is attached to our low-cost psychotherapy plan and serves as its co-ordinator. Where indicated, he arranges psychological testing, calling on the services of our panel members; where a complete psychological workup is required, the psychologist performing this service receives a modest hourly fee in keeping with the intent of the plan.

Once it is determined that a patient is able to use the services of a therapist and is otherwise eligible for help under this plan, he is accepted for treatment and assigned

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<sup>1</sup> The Veterans Administration maintains a regional office in Newark but restricts its out-patient psychotherapy to those with service-connected psychiatric disability.

after clearance with the therapist. Appointments are arranged by the social worker at the convenience of both the patient and the therapist. Therapy is conducted in the private offices of the psychotherapists, thereby enabling the professional who is contributing his services at a reduced fee to spend as little time as possible in traveling away from his office. An additional plus factor in this arrangement is the feeling by many that the private office atmosphere is essential for obtaining the best results.

Each therapist in the plan receives \$5 an hour for his services, and none is permitted to contribute more than five hours a week. Patients who are accepted by the plan pay a maximum of \$5 a visit and remit their fee directly to the therapist. When the patient cannot afford the fee, the Mental Health Association subsidizes his treatment up to the limit of \$5 an hour. At least every three months (and more often if it is thought advisable) the therapists provide the association with a formal report on each patient's progress. These reports are reviewed by the original screening psychiatrist as well as by the co-ordinator of the plan. Psychiatric consultation is available to all non-medical therapists during the course of treatment, and in accordance with established practice the individual therapist, when he considers it appropriate, will use consultation (which is again sponsored by the low-cost psychotherapy plan). In addition to this consultation, it is anticipated that within a short time regular seminars and group discussions of case material will be instituted.

Closer relationships between the therapists and the examining psychiatrists is also encouraged and both disciplines feel they can gain from this form of collaboration. Eventually the plan may take on added teaching value for the participants.

Although the plan operates under the direction of the board of directors of the Essex County Mental Health Association, it is supervised by a professional steering committee composed of leading psychotherapists and social workers in the community, the majority of whom are themselves panel members. This committee screens all applications for panel membership and only well-trained and experienced psychotherapists capable of functioning with a high degree of independence and meeting the professional standards that have been formulated by the committee are eligible for membership.

The plan, as outlined above, went into operation on September 9, 1957. Since then approximately 75 clients have been placed in therapy. They have used 100 treatment hours. They range in age from 16 to 50; about 90% of the patients accepted for treatment are under 40. Most are married, have an average of two children and a mean gross family income of \$4,200 a year. Although our sliding scale is between \$2 and \$5 for each treatment hour, a great number of the patients are able to pay the maximum \$5 fee. Consequently, the amount of subsidization that has fallen upon the shoulders of the Mental Health Association is comparatively little. The total amount budgeted for the project is \$16,700 and covers the salaries of a social worker, secretary, office expenditures and subsidization of therapists. At present, the plan receives 50% of its support from the state under the Community Mental Health Services Act.

It should be borne in mind that this plan is a pilot project of the Mental Health Association of Essex County and that appropriate changes are constantly being made in accordance with the professional recommendations of the advisory committee following a suitable period of study. It is rec-



## *A Low-Cost Psychotherapy Program*

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ognized that the program is not a panacea for the marginal-income group, but in the absence of other out-patient clinical facilities in our county, it offers a sizable proportion of additional resources in a dignified atmosphere conducive to good psychotherapy. The potentialities of this

plan—particularly in contrast to that in other social agencies spending \$20 or more an hour for psychotherapy—will bear careful reviewing. We hope within a short period of time to be able to describe more fully the therapeutic results of our program and the patients we are serving.

# Changing concepts of mental deficiency

The past few years have witnessed a pronounced upsurge of interest in all aspects of mental deficiency. Older concepts are being modified, newer ideas are crowding in, and the entire subject is in a state of flux. This fluidity is reflected most fundamentally in uncertainties over terminology, definition and incidence.

The tendency to avoid the use of traditional expressions for mental deficiency and for the grades of mental deficiency has become increasingly noticeable. The reason would seem to be that these expressions are thought to have become identified with an aura of hopelessness out of keeping with the changing attitude towards mental defectives. Nevertheless, until a newer terminology wins general acceptance there is at

present a risk of confusion from the number of conflicting terms competing for priority.

Suggested substitutes for "mental deficiency" range from "cerebral paucity" (1) to "severe subnormal personality" (2). The latter has behind it the authority of the newly-issued report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957. The report indeed comes out strongly on the side of change. Thus, with regard to severely subnormal patients, or patients with severely subnormal personality, it states: "This term should be used when the general personality (covering intelligence and temperament together) is so severely subnormal that the patient is incapable of leading an independent life. Severely subnormal patients include those at present classified as idiots and imbeciles and some of those now classified as feeble-minded (that is, morons)."

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Dr. Gibson is clinical director of the Manitoba School in Portage la Prairie, Manitoba.

The report goes on to say: "The terms 'idiot' and 'imbecile,' and the terms 'mental defective' and 'defective' should no longer be used." The tendency to get away from the use of the term "mental deficiency" is more marked still in those quarters where the employment of the expression "social inadequacy" is put forward as an appropriate synonym.

A considerable measure of popular acceptance has been accorded the terms "educable" and "trainable" in place of "moron" and "imbecile," whilst "totally dependent" or "extremely retarded" have found favour as substitutes for "idiots." Some time ago Kanner (3) suggested the term "absolute" to include idiots and imbeciles, reserving the term "relative" for morons, on the principle that the limitations of the latter are related to the standards of the society around. Certainly, a term like relative feeble-mindedness undoubtedly highlights one of the leading characteristics of the moron grade, constituting as it does 75% of all defectives in the community. It is possible, however, that later users of the term may have done disservice to the concept by conveying the impression that relative deficiency is of comparatively minor significance in relation to the absolute deficiency of idiots and imbeciles. When it is recalled that up to a century or so ago the obvious defectives were idiots and imbeciles, and that morons subsequently assumed prominence through their inability to meet increasing complexity, the relativity of their defect can be more fully appreciated. But even if the comforting view is adopted that theirs is merely a relative disability as the result of Western emphasis on efficiency and industrialization, the problem is in no way lessened, more especially when it is becoming increasingly clear that industrialization is taking root in hitherto untouched areas of the world.

Similar uncertainty prevails with regard to the relative use of the terms "mental retardation" and "mental deficiency." At one time they were used more or less synonymously but the trend latterly has been to differentiate more clearly between them. "Mental retardation" is generally used with reference to all cases with an intelligence quotient under 70. Employed in this fashion it includes two or more subgroups. It includes, for example, probably the bulk of mental defectives, where intellectual retardation is associated with social incompetence. It also includes the subgroup characterized by intellectual retardation without social incompetence. This section is variously known as mentally handicapped or educationally defective, which again is quite distinct from educationally retarded or merely backward. By some writers the term "mental retardation" is applied exclusively to cases of intellectual retardation without social incompetence, although its use here has been criticised on the ground that retardation in the educational sense need not necessarily denote retardation in the psychological sense.

Whilst a simple dichotomy of this nature is fairly common there are more elaborate subdivisions which, useful though they may be in practice, nevertheless add appreciably to the risk of semantic confusion. Thus one writer (4) subdivides the concept of mental retardation into five categories: mental deficiency, defined as a general inadequate adaptation; mental defectiveness, or a scattered impairment of abilities; mental deficit, or attention and concentration defects in brain injury, for example; mental inadequacy, or borderline cases induced by cultural, social or educational factors; and, for good measure, pseudofeeble-mindedness, which is defined as an apparent deficiency on the basis of emotional and intellectual disorders.



If we should for the present regard the term "mental deficiency" as legitimate verbal currency we still have difficulty in finding a generally acceptable definition. The English legal definition in the Act of 1929 defined it as "a condition of arrested or incomplete development of mind existing before the age of 18 years, whether arising from inherent causes or induced by disease or injury." A definition quoted by the Scandinavian writer Kemp (5) is more explicit in defining it as "a state of incomplete development (of mind) of such a kind and degree that the individual is incapable of adapting himself to the normal environment in such a way as to maintain existence independently of supervision, control or external support." In the Wood report (6) a mental defective was defined simply as "one who by reason of incomplete mental development is incapable of independent social adaptation." Extreme emphasis on defect of behavioural adaptability as the main criterion of mental defect distinguishes the view propounded by Delay and colleagues (7) that social incompetence in the presence of a good intelligence quotient may be really a camouflaged mental deficiency.

Meyer-Gross (8), on the other hand, uses the term "mental deficiency" to signify "a condition of subnormal mental development present at birth or in early childhood, and characterized mainly by limited intelligence." Limited intelligence as the cardinal feature is also stressed in the United States, where, for example, the statistical manual for institutional use defines a moron as "a mentally defective person usually having a mental age of 8 years or upwards, or if a child, an intelligence quotient of 50 or more, with a quotient of 69 as the upper limit for a diagnosis of mental deficiency."

Then there is a physical criterion of mental deficiency which under some circum-

stances may be the most applicable. As Penrose (9) has pointed out, it is fairly obvious, quite apart from the application of social and intellectual criteria, that an untreated cretin or phenylketonuric will come within the scope of mental deficiency.

Finally, some workers take up the position that there can be no firm diagnosis until maturity. This, for example, is the stand taken by Doll (10). In this view the more conservative term "potentially mentally deficient" is suggested for children who have not matured.

Lack of complete uniformity is therefore still obvious in deciding what constitutes mental deficiency. Whilst it is more usual to regard intellectual retardation as the cardinal feature, with social incompetence as a manifestation, nevertheless for others the kernel of the problem is social incompetence, not necessarily accompanied by reduced intelligence. On the whole, however, it is fairly widely conceded that both intellectual retardation and social incompetence are necessary, the emphasis placed on each component being subject to variation. What emerges is a broad basis of agreement that the essential manifestations are intellectual retardation and social incompetence from an early age, with perhaps a corollary that the conditions which lead to the underlying arrest or incomplete development of mind may also manifest themselves physically. The mental defective may consequently attract attention because of his lack of intellectual progress, his social incompetence, and perhaps the distinctive physical picture he presents. Thus he may show himself unsuitable for education under the ordinary educational system, he may prove quite incapable of managing himself and his day-to-day life with ordinary common sense, and he may at the same time vary physically from apparent normality to the abnormality of mongolism or cretin-

ism. Because of the degree of his deficiencies he is in need of care, supervision and control.

Closely connected with the concept of mental deficiency is that of pseudodeficiency or pseudofeeble-mindedness. This latter term has acquired considerable vogue in recent years. It is employed with reference to individuals labeled mentally deficient at one period of their lives but who later are not so regarded. The inference is then drawn that these individuals were not mentally defective in the first place but only pseudofeeble-minded. The diagnosis is therefore made in retrospect. Like "mental deficiency" the term is subject to a number of interpretations. Thus it has been interpreted as meaning a state of delayed maturation. However, as McCandless (11) has pointed out, persons who are defective because of delayed maturation just cannot be differentiated by current procedures from those of the same tested level who are defective from other causes.

Another view is that recently propounded by Benton (12) that pseudofeeble-mindedness should be regarded actually as mental deficiency of atypical etiology. This may be of a physical nature, as in visual or auditory handicap, or motor deficit of cerebral palsy. It may be psychological, where emotional disturbance is thought to inhibit the acquisition of basic mental abilities. It may finally be social, the result of unstimulating social or family environment or inadequate schooling. Pointing out that the typical effect of physical or social handicap is a comparatively minor drop in intelligence level, the author speculates that it may be different in the case of children whose intellectual potentialities are reduced from the commencement, or where multiple handicaps occur. In Benton's opinion, pseudofeeble-mindedness may result from either the interaction of a specific handicap

with an intelligence which, though subnormal, is above the defective range, or from multiple handicap in a child of average intellectual potentialities. It need scarcely be stressed in passing that the main effect of social handicap is in the social aspect itself. In this connection the wise handling of a case may well result in the development of an ability to cope with the demands of society, and if this is achieved the mental deficiency in the social sense is reduced or eliminated to a point where the diagnosis is no longer appropriate.

Not infrequently the term "pseudofeeble-mindedness" seems to be employed merely to signify a mistaken diagnosis which has become apparent in the course of time. When it is used in this manner its scope is very greatly increased, although it is certainly open to the criticism that diagnostic errors should not be elevated to the status of a clinical entity (12). Used as a synonym for differential diagnosis it may refer to any one of a considerable range of conditions.

Since mental deficiency is characterized by both intellectual retardation and social incompetence it has to be distinguished from certain states where only one criterion is present, or appears to be present. In actual practice this involves consideration of three separate groups: conditions characterized by intellectual inadequacy alone, specific defects of a visual, auditory or speech nature which may superficially resemble intellectual retardation, and conditions characterized by social incompetence alone (13).

The group where intellectual inadequacy alone is present includes cases of intellectual retardation without social incompetence, who are sometimes referred to as mentally handicapped; cases of dullness; and, since a substantial proportion of backward children, or children with educational retardation, have subnormal intelligence, consideration has also to be given to this class.

Specific defects of a visual nature include conditions like congenital blindness, visual cerebral injury and congenital word blindness; those of an auditory nature take in congenital deafness, high-tone deafness and congenital word deafness, whilst among speech defects are mutism, delayed development and congenital motor aphasia. Where social incompetence alone is in question it may be a matter of delinquency from such causes as maladjustment, adolescent instability or frank psychopathy. In some cases it may be the aberrant behaviour associated with convulsive disorder, and in yet others it may involve actual psychosis.

Some groupings are naturally encountered more frequently than others. A rough guide to their relative incidence may be obtained from cases referred to mental deficiency clinics. Thus of the first 250 cases referred to one group of clinics (14) only 104 were actually defective. Of the remainder the largest number—89 juveniles and adults—fell into the subnormal section. The next largest number—50 cases—made up the section characterized by behaviour disorder of delinquent, convulsive or psychotic type, whereas only 7 cases could be included within the section of specific defects.

The uncertainties in terminology and definition have their counterpart in incidence. The general incidence of mental retardation has been estimated at anything from 10 to 50 per 1,000 of the general population. A recent publication of the National Association for Retarded Children (15) cites an incidence for the United States of 30 per 1,000, specifying that out of every 30 retarded children 25 are educable, 4 trainable and 1 totally dependent. A prevalence study of mental retardation conducted by the Mental Health Commission in Onondaga County, New York in 1953 and 1954 (16) tended to bear out this incidence. It reported that from birth through eighteen

years  $31\frac{1}{2}\%$  of the population were mentally retarded. It should, however, be mentioned that the Onondaga County study was of cases reported as mentally retarded, although these reports were not confirmed by clinical study.

In the case of mental deficiency, variation is still more apt to be encountered. In fact, it seems unlikely that any estimate could be found with universal application. Since the ranks of defectives are usually swollen by a proportion of individuals with a mental level above that of the retarded, the number of defectives will naturally vary according to the different criteria in force. Thus in England, which has always underlined the social component of mental deficiency, certification may take in a section with an intelligence considerably higher than the retarded range. Just how high was recently indicated by an investigation of institutionalized defectives in the greater London area. The investigators (17) claimed that half the adult patients certified as feeble-minded (or moron) and placed in institutions were dull rather than retarded, with an average I.Q. of 70.

So far as actual estimates are concerned a commonly quoted figure in the United Kingdom, based on the extensive work done by the Wood Commission in 1929 (6) is 8.6 per 1,000 for the population as a whole. It was left, however, to Penrose (9) to point out the wide fluctuation which occurred when the commission's report was analyzed according to age groups. In the 30 to 39 age group, for example, the incidence was only 5.7 per 1,000, whereas between the ages of 12 and 13 years it reached its peak incidence of 30 per 1,000.

A more recent survey carried out in the eastern health district of Baltimore (18) furnished an over-all incidence of 12.2 per 1,000. Both surveys showed their maximum incidence between the ages of 10 and 14



years, with marked falling-off above and below these ages. Within these age limits the respective figures were 25.6 and 43.6 per 1,000. By comparison the proportions between the ages of 40 and 49 were only 5.4 and 7.4 respectively. According to Penrose, the reduction in incidence following the scholastic period occurred because what he termed the "rigid standards of scholastic environment" no longer applied, whilst the later choice of suitable employment aided adjustment.

The Wood Commission made it clear that its findings represented the number of persons who were incapable of independent social adaptation because of incomplete development of mind, and that they did not include children who were educationally rather than socially defective. Subsequent opinion, however, has tended to regard its estimate of 8.6 per 1,000 as too conservative, and quite possibly the Baltimore incidence of 12.2 per 1,000 may be nearer the mark. Fremming (19), indeed, claims that recent Scandinavian investigations show that 10 to 15 per 1,000 of the population are certifiably mentally defective. Kemp (5), also dealing with Scandinavian material, makes no attempt to form an accurate estimate but contend himself with indicating that what he terms the "true mental defective," as distinct from the mentally retarded, probably constitutes 10 to 20 per 1,000 of the population.

Nevertheless, such estimates relate primarily to cases potentially certifiable rather than actually certifiable, since certification depends on the demonstrated need for care and control. The number of those who actually require to be certified is fortunately much less. It includes certified institutional defectives as well as those certified under guardianship. Here again it is difficult to reach finality. In 1954, for example, in England and Wales there were about 56,000

institutional cases compared to approximately 82,000 cases under guardianship and on licence from institutions in addition to cases under statutory supervision, the total number amounting to practically 3 per 1,000. In the same year, in the same island, there were in Scotland approximately 5,000 institutional defectives and fewer than 3,000 cases under guardianship or on licence from institutions, providing a total estimate of about 1.5 per 1,000.

The provision of purely institutional accommodation is generally based on an estimate of 2 per 1,000 of population, but the degree to which it is allocated between high- and low-grade patients is again subject to variation. Thus, if all low-grade cases were institutionalized the total accommodation would clearly be exhausted by this group alone. However, Penrose (9) estimated that in England and Wales, for example, the institutional population represented 3% of high-grade and 25% of low-grade defectives in the community. Since until recently the tendency has generally been to regard low-grade defectives as primarily a custodial problem, the fate of the remaining 75% assumes some significance.

A partial answer to this question is provided in a report published late in 1957 by the New York State Interdepartmental Health Resources Board (20) concerning the findings of a study made by the research center of the Graduate School of Public Administration and Social Services of New York University. The object of the study was to find out what proportion of severely retarded adults managed to remain outside institutions, and the type of adjustment they made in the community. The group chosen was not representative of all low-grade adults but was principally limited to the section with I.Q. between 40 and 50 who had attended low I.Q. classes in New York. In operation since 1929, these classes had

originally accepted pupils with any I.Q. below 50 but since 1941 had limited their intake to the 40-50 I.Q. range. It was found that out of a total of 2,640 former pupils between 17 and 40 years of age at the time, 26% were in institutions, 8% had died since leaving school, and 66% were living in the community. Of those in the community the bulk spent the greater part of the day at home, and only a third were capable of leaving their immediate neighbourhood and getting around by themselves. About 7% got into trouble, mainly minor offences like vagrancy and peddling without a licence. No fewer than 27% were working for pay. Admittedly most of them obtained their earnings by carrying out simple household chores, but one in three was able to find employment in stores or unskilled work in factories. Of those working at the time of study half earned more than \$20 a week and a few earned up to \$40, \$50 or even \$60 a week. However, the report does not fail to establish the dependence of the group on parents and relatives, whilst a further point that emerges is the increasing demand for services like day-care centers, workshops and recreation centers to assist in retaining them within the community.

These then are some of the trends and uncertainties which are apparent in the sphere of mental deficiency. Though it is obvious that uniform agreement on some fundamental issues still eludes our grasp we have at least a reasonable hope that the rising interest in all aspects of the subject may throw a clearer light on current problems.

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ROBERT S. MORROW, Ph.D.

MARGARET M. KINNEY, M.S.

## The attitudes of patients regarding the efficacy of reading popular psychiatric and psychological articles and books

The number of popular books and articles concerning psychological and psychiatric topics is very extensive. Several of these books have been best sellers year after year. This general interest, as noted by publishers, librarians, booksellers and psychologists, is a source of much comment, but few studies deal with the people who read this literature, or with why it is read, or with whether any direct value is derived. The same is true of the literature considering the therapeutic value of books and reading in general—that is, bibliotherapy. In some 500 items listed in the bibliographies of this subject few attempts have been made to determine scientifically such questions as these.

The patients in our hospital—a Veterans Administration general medical and surgical hospital—we felt would be a suitable population in which to investigate some

of these questions, since one finds here a representative cross section of the adult male population.

The opportunity to do the study came shortly after *Life* magazine January 7, 1957, began to publish a series of five articles on psychology. These were used as a central point in our investigation. Specifically, we set up a pilot study designed to answer the following broad questions:

1. Do psychiatric patients in general read more psychiatric and psychological material than nonpsychiatric patients?
2. Do these two groups indicate different kinds or degrees of feelings and attitudes toward such literature?

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Dr. Morrow is chief clinical psychologist and Miss Kinney chief librarian at the Veterans Administration Hospital in The Bronx, N. Y.



## METHODOLOGY

We designed for simple individual or group administration and evaluation a questionnaire containing 10 questions. These items are presented with the results. The librarians who visit the various wards with the reading material asked patients selected at random to cooperate in filling out the questionnaire. They were present only to help clarify some of the questions or to interview the patient if his disability interfered with writing.

The Veterans Administration Hospital in the Bronx has approximately 1,300 patients. Of these only 150 are psychiatric cases, most of them in fairly good contact with reality. We selected randomly from this group only the open-ward patients—that is, those who were not grossly psychotic or unduly disturbed and whose answers could be considered valid.

Fifty-six such patients answered the questionnaire. Their mean age was 35.9 years with the range from 22 to 59. (Patients over 60 were not used in the study.) Their educational level was at a mean of 11.2 years of schooling with a range from 3 years to 16 (16 years was established as the ceiling even for those with graduate and professional school training). To see whether the length of stay in the hospital had an effect on attitudes, the length of the patient's hospitalization in weeks was obtained. For this group the mean hospital stay at the time of the interview was 12.6 weeks, with the range from 0.5 weeks to 52 weeks.

Of the nonpsychiatric patient population 84 were randomly chosen from the various medical, surgical and rehabilitation wards. This group was composed of the following: 17 paraplegic, 10 surgical, 12 tuberculous, 20 chronic medical, 15 recuperating from medical conditions and 10 dermatological

patients. Taken as a single group, their average age was 38.0 (range from 21 to 60); average education 11.2 years (range from 5 to 16 years); hospital stay 13.2 weeks including the paraplegic patients, 11.1 weeks without the paraplegics. On the whole, using as controls age, education and length of stay in the hospital, the psychiatric and nonpsychiatric groups appear to be fairly similar.

## TEST RESULTS

The table summarizes the answers of the two groups of patients to the questionnaire. Since there is a difference in the size of these groups, the results have been made comparable by converting into percentages the responses to each question.

It can be seen that there is great similarity between the groups in answering the first item since about two-thirds of each stated that they enjoy reading books and articles on psychology and psychiatry. In the next item, however, there exists an important difference as to whether they find these helpful or not, with more of the nonpsychiatric group reporting them as helpful. A suggested explanation as to why more nonpsychiatric patients consider this material helpful is that they may feel that this should be so theoretically, whereas the psychiatric patient more likely reports from experience and disillusionment.

There appears to be a basic difference with regard to item 3 in that more of the psychiatric patients seem to be directed to this literature through their own curiosity and search for self-help. The nonpsychiatric patients are somewhat more dependent upon others to make recommendations. The library is a constant source of reference for both groups. As to who recommended the material or other sources of direction, too few patients answered to give sufficient information.

## Summary of results on questionnaire

ITEM	PSYCHIATRIC		NON-PSYCHIATRIC	
	(Percent Answering Affirmatively)			
1. I do not enjoy reading books and articles on psychology and psychiatry	68		67	
2. I feel that articles and books of this kind are helpful not helpful	72		84	
3. How are you directed toward these books and articles? (answers in percentages)				
	Self	Recommended	Library	Others
Psychiatric	57	10	17	16
Nonpsychiatric	49	16	16	19
4. How much time do you spend in such reading? (answers in percentages)				
	Occasionally	Frequently		
Psychiatric	94	6		
Nonpsychiatric	96	4		
5. Were you interested in reading in this field before coming here?	72		68	
6. Do you intend to continue this interest?	63		66	
7. Does your reading of this type consist mostly of				
	(a) Books	33	(a) Books	31
	(b) Articles	67	(b) Articles	69
8. Have you read any of <i>Life</i> magazine's recent series of articles on psychology:				
	(a) None	31	(a) None	47
	(b) Some	58	(b) Some	48
	(c) All	11	(c) All	5
9. What did you think of the <i>Life</i> articles?	89		91	
10. Were any of your personal questions answered by the <i>Life</i> articles?	53		38	

Most of the patients indicated on item 4 that their reading in this area is occasional rather than frequent or regular. There is not much difference between the groups on items 5 and 6, which deal with interest in reading this literature before hospitalization and subsequent to it. However, while the psychiatric group was somewhat more interested initially, they indicate a 9% drop in continued interest, whereas the nonpsychiatric group of patients remain pretty much the same. Two explanations are suggested. One is that the psychiatric patients have not been able to find satisfaction or solution for their problems in the literature, and this drop represents their disappointment. Another

possibility is that these patients are receiving psychotherapy and no longer need outside help or, as sometimes happens, they are requested by their therapists to discontinue such reading so as not to become confused.

Item 7 indicates that both groups read articles much more frequently than they read books. There was a fairly high overlap involving both categories to indicate that there are many who read books as well as articles. This seemed to occur more often for those whose preference was for books and who added comments to show both. There is a substantial difference between the two groups on item 8, which shows that a higher percentage of the psy-

chiatric patients was interested in the *Life* magazine articles on psychology. This is shown by the fact that of the two groups a larger number of psychiatric patients read some of the articles and twice as many were sufficiently interested to read all of them. Of those who read some or all of the series there is no substantial difference between the two groups on item 9 since approximately 90% of both groups expressed positive attitudes. What is more significant is that item 10 showed that more of the psychiatric patients felt that they received answers to some of their personal problems. As a matter of fact, more than half of the psychiatric patients who read at least some of the articles felt this way while only about one-third of the nonpsychiatric group expressed this attitude.

The fairly large difference between those who express positive attitudes in general toward this literature (item 8) and those who state that they derived personal help (item 10) tends to show that these feelings and attitudes are abstractly determined rather than rooted in personal experience. This is exemplified by the patient who remarked that "I, myself, was not helped but I know it's supposed to help you."

At the end of the questionnaire both groups were asked in what respects more information would be wanted, and very few answers were given. This would indicate either that the patients involved in this study regard the literature as already sufficiently complete (which does not seem too likely) or else they do not feel competent to make suggestions. Where suggestions were offered, they most often requested that the material be presented as TV and radio programs rather than in printed form. A few suggested such topics as more information about psychotherapy and psychoanalysis, abnormal psychology, normal behavior and child psychology.

## DISCUSSION

The results of this preliminary investigation indicate that while the psychiatric and nonpsychiatric population are not basically dissimilar in regard to their interests in psychological and psychiatric literature, some meaningful differences do emerge.

It can be seen that the psychiatric patients begin with greater interest and curiosity but that more of them express disappointment as far as tangible benefits from their reading are concerned. This does not, however, apply to the *Life* articles on psychology. Here the attitude expressed by those in both groups who had read some or all the articles was very favorable, but the psychiatric patients reported a higher degree of satisfaction or help. This would tend to indicate that books and articles written by experts in the field are more likely to be satisfactory or beneficial.

It is axiomatic that people have different motives for reading. These involve personal motivation as well as intellectual curiosity, literary enjoyment, etc. Of significance is the fact that 70% of this typical patient population borrows books. The reading of psychological literature seems to be in accordance with the general interest in reading—that is, 68% of the psychiatric patients and 67% of the nonpsychiatric indicate they enjoy reading psychological literature. The only difference seems to be in whether they find the material helpful or not. The fact that the majority of those who read this popular psychological literature find it helpful seems to refute Wertham's opinion that they only *think* they are being helped. This would be an area for further investigation.

It is also of interest to note that a good number would like to see some of this material presented in more entertaining fashion such as TV, radio and movies. Inspection of the data indicates that this



attitude was more prominent among those who claimed they did not enjoy this type of reading. The question we could not answer at this time is whether there is a high correlation between the 30% non-readers and those who claim they did not enjoy reading this literature. We would suspect that there is.

In analyzing the data we were impressed with the fact that the answers were, for the most part, superficial and that there was a need to go deeper, to determine the reasons behind the answers. If the person felt this literature was helpful, it should be important to know how or why; or if he expressed the feeling that it was harmful, we should find out in what way, etc. This could be determined by means of a focused individual interview rather than a questionnaire such as this.

It seems, in retrospect, that while the grouping of all this literature was helpful in obtaining a general or over-all viewpoint, some aspects require further elucidation. The fact that there was a difference in attitude toward the *Life* articles could mean that there might be felt individual differences toward other types of special books and articles, including some of the titles that made the best seller list. In other words, why were they so popular? Were readers impressed by the fact that this was a best seller and that some of the material should have been absorbed by them, or were the books and articles helpful, indeed, to the host of readers?

It would be of interest to study larger groups to see to what extent factors such as differences in age, education and length of stay in the hospital might influence or condition differences in attitudes. The fact that we have combined all the non-psychiatric patients into a single medical control group needs further thought and investigation. The intergroup differences

in attitudes on larger samples are worth studying to determine whether or not there are discreet subgroups.

As regards the psychiatric patients, it would be interesting to find out from them, as well as from their therapists, the extent to which such reading material is discussed in therapy. Another study which seems worth doing would be to determine how the hospitalized male population compares with nonhospitalized male controls and, if the two groups are similar, to consider broadening the utilization and application of these data for the population at large.

The findings suggest that a sizable number of patients was helped or at least influenced by the availability of the reading material in the library, as well as by the recommendations of librarians. It would be a fruitful source of investigation to compare attitudes and progress of patients in hospitals having libraries and librarians with those without libraries.

As was stated in the introduction, this study was undertaken in order to examine the attitudes of patients at this hospital toward the efficacy of reading popular psychiatric and psychological books and articles. The results have indicated that such reading material is considered valuable and that the library has an important place in its selection. The study itself has indicated a possible technique for further studies, as well as potential areas for future investigation.

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A. E. ROSÉ, B.A.

C. E. BRAWN, M.A.

E. V. METCALFE, M.D.

# Music therapy at Westminster Hospital

## SURVEY OF THE LITERATURE

A survey of the literature readily available to us reveals a wide variety of therapeutic uses for music, some in which music is the core of the therapeutic method and some in which it is an adjunct to other therapies. Our survey also suggests some lack of clarity and objectivity in thinking, in theorizing and in reporting on activities in this field. In discussing the literature we shall limit ourselves to an attempt to pinpoint some of the highlights and deficiencies, and to classify the main uses of music as therapy.

Some writers deal with historical evidence of the healing power of music, ranging from the statements of Plato and Aristotle to the phenomenon of "tarantism" in Apulia, the use of music by primitive "medicine men" (9), and semi-magical

cures through music down to more recent times (21). These are of greater literary and historical than scientific value.

The value of music seems generally accepted as a relaxing and stimulating agent when used as background throughout any hospital. There appears, however, to be room for more objective evaluation of results where music is used thus extensively. Some of the clearer thinking in this field appears in articles describing the empirical use of music with many types of therapies as a distraction device, anxiety reliever and

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Mr. Rosé is music therapist at Westminster Hospital in London, Ontario, and professor of music at the University of Western Ontario. Mr. Brawn is a psychologist at Westminster Hospital, where Dr. Metcalfe is chief of psychiatry service. Dr. Metcalfe is also senior associate in psychiatry at the University of Western Ontario.



relaxing agent. For example, it has been reported as of considerable value with surgery (22). It has also been reported as reducing the trauma and enhancing the relaxing effect of electro-coma therapy (16, 17).

As a direct agent, music has been used in treating both organic and psychiatric disorders. It has been of value for its rhythmic character in teaching co-ordination to retarded and cerebral-palsied children (12) and to brain-damaged patients (8). This may involve rhythmic physical activity aided by music, and in some instances the playing of rhythm instruments. Other active therapies using music are group singing, learning to play instruments, and the like with psychiatric cases (4, 6, 11). The value of such therapies seems empirically sound.

Various approaches have been taken with passive types of music therapy involving listening or exposure to music. Some authorities have attempted to relate the effect of specific types of music and even of specific selections to the diagnostic classifications of patients (18). Some have attempted to relate the effects of music to physiological change involving the autonomic nervous system or other metabolic processes (7, 10). Schoen says, "The sensorial response is physiological and possessed by all" (19). Others discuss the effect of music on emotions in more aesthetic terms which are difficult if not impossible to validate scientifically (2, 14). A few articles appear in which an attempt has been made to test and evaluate the effects of exposure to music empirically and objectively. For example, Mitchell and Zanker have carried out an experimental approach to music therapy (15). Blair and Brooking also report similar experiences and conclusions from their "music appreciation groups" (3). Their approaches involve rela-

tively small groups of patients listening to and discussing music with therapeutic results as a goal.

In summary, it appears that the following are the most important lines upon which music therapy is developing:

1. The use of rhythm to aid co-ordination, to stimulate activity and to encourage group participation.

2. The exploration of emotional responses to various types of music.

3. The use of music as a pleasurable experience in a group setting to stimulate discussion of moods and experiences.

We propose in the following pages to describe our own experience using this last approach with psychiatric patients.

## BACKGROUND

In the fall of 1952 consideration was given to the inclusion of music in the broadening therapeutic program at Westminster Hospital. In the light of our understanding of music therapy under way elsewhere at that time, we felt that we could not proceed on predetermined lines, but only through a long and painstaking trial-and-error approach.

The proposed music therapist had had wide experience in various fields of music, performing in concerts and conducting opera, symphony and choirs, and was therefore accustomed to handling individuals as well as large groups of people. Would it not be possible for him, through a variety of musical media, to interest and maintain the attention of a group sufficiently to stimulate a discussion of the music and so lead into a group discussion involving the patients' emotions and problems?

In November 1952 a tentative program was established. At first one session a week was scheduled in a room with comfortable armchairs, tables and smoking facilities,

having no resemblance to any of the treatment rooms. We had the use of a piano, a small portable record player and a blackboard. Each group consisted of eight or nine patients with one male and one female nursing attendant or nurse present. The session lasted from an hour to an hour and a half.

The program for the session included listening to and discussing records, and perhaps the life history of the composer or the performing artist, or any subject arising out of the discussion. Sometimes there was ensemble singing, in which we used books containing well-known art and folk songs. Eventually we saw that one period a week was insufficient. The lapse of time between sessions was found to be too long to assure continuity of procedure; memory often failed and we felt impelled to start our program from the beginning. To avoid this discontinuity and ensure a continuous series which would arouse and hold the interest of the patients from one meeting to another, we instituted in January 1955 two sessions a week for each of two groups.

### AIM

From the beginning, music therapy in this setting was envisaged as a type of group therapy with music as a stimulating medium. We hoped that the music would arouse the wish in the patient to associate himself with the mood of the composition, thus bringing him to express his feelings and perhaps identify with the composer. In sharing the emotions stimulated by the music, he might often be relieved of tension, or by speaking about the feelings which the music had brought closer to the surface, might become aware of problems which bothered him at that time.

Van de Wall has expressed these same points as follows, "Through the process of

association then, music may increase our awareness of that part of the world which lives inside of us as well as of the external world, and also of the dynamic relation between the two. The process of association under the stimulus of music may build a bridge between ourselves and our environment, ourselves and the present, but it may also break off for the moment our relation with reality and the present and may isolate us in an imaginary world and time far removed from the place and people constituting our momentary physical and social environment" (20).

While the arousing of feeling and the facilitation of its expression are of first consideration, another important aim is to exert a socializing influence on patients. A function of the music is therefore to provide a purpose for the meetings in which changes in social consciousness may develop, ranging from toleration of others in a group situation to self-expression in a group and development of some social skills. Certain other benefits are expected to accrue—that is, the generally stimulating effect of the sessions as entertainment, some relief from the monotony of hospital life, the ego-enhancing effect of the attention received by patients in the group, and the possible development of a new interest. In addition, while the acquisition of knowledge of music is not an aim, it is expected that to some degree this will occur.

Music therapy is not expected to cure; it is one of the many aids we are trying to find to make general treatment more effective. We feel that we should always keep in mind that these sessions are not intended to instruct patients in music in order that they may "pass an examination" or make a professional choir or ensemble. Music is a universal language which does not have to be translated or re-formed to be understood. It affects the emotional

part of the human being without making it necessary for him to use his intellect. Music should be a means by which we try to reach the emotions of the patient, so that he may be conditioned to a more receptive basis for psychiatric and medical treatment.

## REFERRALS AND COMPOSITION OF GROUPS

Patients are referred for music therapy by the psychiatrist. Sometimes referrals are on the suggestion of the psychologist or on the patient's own request. While the crit-

eria for referrals are rather flexible, in general they are the patient's capacity to benefit from the experience and to contribute to the group's activities.

Each group consists of from 6 to 12 patients, one male and one female attendant, the music therapist and a psychologist. The psychiatrists also join the group when they wish. Patients are predominantly male since the proportion of female patients in the hospital is small. No selection according to diagnosis is exercised though there is a preponderance of schizophrenics because of their numerical superiority in

## Music Therapy

### Referral form

### Psychiatric Institute

NAME OF PATIENT ..... AGE ..... DATE .....  
 DIAGNOSIS ..... WARD ..... PRESENT TREATMENT .....

### PRESENT ATTITUDE AND BEHAVIOUR OF PATIENT:

General:	Hyperactive?	Retarded?	Depressed?	Hallucinations?
<i>Social attitude:</i>	Withdrawn?	Negativistic?	Apprehensive?	
(check or circle	Hostile?	Irritable?	Suspicious?	
relevant words)	Sociable?	Cooperative?	Cheerful?	
	Passive?	Aggressive?	Tense?	
	Manneristic?			
<i>Conversation:</i>	Spontaneous?	Relevant?	Intelligent?	
	Appropriate?	Hard to elicit?	Reluctant?	

### PATIENT'S INTEREST IN MUSIC:

Did patient ask to come:	Yes?	No?
Did he express positive interest when approached:	Yes?	No?
Has he specific interests in music?	Please specify	
Has he special training in music?	Please specify:	

### SUGGESTIONS FOR HANDLING:

### FAMILY BACKGROUND, EDUCATION, SOCIAL STANDING:

### CAUSES OF ILLNESS:



the hospital. Some patients are from closed wards and some from open wards. Disturbed patients are not excluded unless they are disrupting to the group. In making new referrals, other aspects being equal, priority is usually given to recent admissions, patients on an active treatment program, and patients with relatively favourable prognosis. At present there are two groups, each meeting twice weekly. While it is intended to keep the groups fairly equivalent, their degree and type of responsiveness varies according to the personalities of the patients in each, and new referrals are often allotted to the group in which it is felt they will fit best or can make their best contribution. As far as is feasible, the groups are kept equal in number. Our referral form, on page 96, is self-explanatory.

#### SELECTION OF THE PROGRAMS

We feel that "classical" music (including modern compositions) offers the best possibilities of arousing feeling and stimulating discussion. A wide variety of symphonies, concertos and other ensemble music has been used, as well as vocal works, although some lighter selections such as folk songs and songs from musical comedy have been played. On rare occasions modern jazz and popular singers have been heard at the specific request of some patients.

The therapist himself chooses the music to be presented, although suggestions from the group are always welcomed. In the selection of music he has been guided by a number of observations gathered in a lengthy period of experimenting. While the response to the music played is still unpredictable, certain guides have proved effective:

- It is important that variety be applied to the choice of programs. The therapist

draws from his own large record collection as well as from a growing record library in the hospital.

- In the therapist's opinion, patients are most affected by changes in the tempo of the music. Other factors governing the therapist's choice, in order of importance, are rhythm, melody and harmony.

- The therapist believes that orchestral music is more likely to arouse interest than other types. Music of varied emotional colour will provide a range of opportunity for the patient to express feelings.

Mitchell and Zanker (15) have tried to establish the characteristic reactions of their groups to various styles of music: classical style, including Bach, Handel, Haydn, Mozart, Beethoven; romantic style, comprising Schubert to Brahms and Wagner and the nationalist composers such as Grieg, Dvorak, Mussorgsky; modern impressionist style, as for instance Debussy, Saint-Saens, Butterworth; and contemporary music, such as Sibelius, Stravinsky, Bartok, Hindemith.

Capurso (5), on the other hand, has exposed a group of normal subjects to music selections, and has asked them to choose one of the following six categories, which would described the effects of the composition:

- A Happy, gay, joyous, stimulating, triumphant
- B Agitated, restless, irritating
- C Nostalgic, sentimental, soothing, meditative, relaxing
- D Prayerful, reverent
- E Sad, melancholy, grieving, depressing, lonely
- F Eerie, weird, grotesque

Both these above approaches, then, ostensibly provide a guide for the selection of music which will have given desired effects on the patient-listeners. However,

in our own work, although we have noted apparent effects of certain selections on patients, we have found that these effects are not consistent or predictable. We therefore agree with Blair and Brooking, who state in this regard, "It is our contention . . . that the mental attributes associated with the appreciation of music are so complex, the variation of response so vast from one individual to another and from one time to another within the same individual, the variety of musical compositions so enormous, and the circumstances of each person so changeable from day to day, that no scientific statistics are ever likely to be produced for music therapy" (3, p. 234).

From time to time, as special needs or opportunities arise, we try additional activities and procedures. Occasionally films of musical interest are shown to the groups, enabling them to visualize what they hear. (There are about 20 films available to us from the National Film Board, ranging in duration from 9 to 42 minutes.) Subjects are vocal performances, orchestral programs, ballet and folk songs. In scope they range from classical music to jazz and include solo work and small combinations.

Another activity the patients experience is a series of concerts held at the University of Western Ontario on Sunday evenings. These performances offer a variety of singers, instrumentalists and choirs. Therapist, psychologist, patient, attendant and volunteer-driver enjoy these concerts as social equals in all respects. These concerts also give interesting discussion matter in subsequent music therapy sessions.

It is gratifying to notice the increased attention and appreciation on the part of the patients when live music is also brought into the groups themselves. As Licht states, "There is . . . a sense of satisfaction in the corroboration of the auditory and visual images. When the sound is musical the

desire to see its production is greatly increased" (13). These live programs appear to have played a part in arousing the wish in some patients to perform on an instrument themselves. Some have had previous training and others have no instrumental background whatsoever. One patient, who had some knowledge of the piano, prepared and presented a short program for the group, which was warmly applauded. This brought about a feeling of self-assurance and achievement in the performing patient. Another patient (leucotomized in 1951) after a year of piano instruction begun in 1955 has recently shown increasing sensitivity to phrasing and dynamics without specific instructions from the therapist.

Another case of individual sessions has been successful. This patient had a high-pitched voice, of which he was very conscious. For some months the therapist held regular voice sessions with him. After approximately four months he was able to use a normal range without effort and could sing some easier songs in baritone. The knowledge that he could speak and sing in a normal and inconspicuous range greatly helped his self-confidence and general attitude.

It remains to be seen if, in case of specially talented or interested patients, individual therapy sessions will speed up any improvement and complement the team work, or make patients less adaptable to group meetings.

#### PROCEDURE

As noted earlier, the groups meet in a comfortable, informal setting. At present a record player of good reproductive quality with automatic record changer is used, an improvement over the portable player originally provided. Records are selected and the machine is controlled by the music therapist. Each other member of the group

selects his location from the chairs arranged in a circle which includes the therapist and the record player. Attendants sit in the group or remain at the back of the room as they wish.

When the group is assembled and initial casual conversation has died down a record is started by the therapist, usually without preamble, or at least without giving the title or composer or any information as to the nature of the music. Whenever natural breaks occur in the music—for example, the end of a movement—they are used as stopping places for discussions, several such usually occurring in the course of a session. Each break lasts as long as patients are interested in discussion; then the recording is continued or another selection played. The therapist and the psychologist join in the discussion and attendants have at times taken part.

In fostering the atmosphere of equality which was desired and in realizing our aims of socialization and expression of feeling, certain devices and techniques have developed. Patients often require some time after the music ceases to compose themselves to speak, and the temptation for the psychologist or therapist to break the silence is resisted unless no patient speaks for at least a full minute. The value of such periods of silence, however, are dependent upon a relaxed appearance and attitude on the part of the psychologist and the therapist since any tension on their part is quickly conveyed to the group. Nor should there be any pressure to speak felt by patients in the form of expectant looks. These will make some uncomfortable, causing a desire to withdraw, while others will comply by making a type of remark which expresses no real feeling. Each remark made by a patient is acknowledged if addressed to the psychologist or therapist, or if no other member of the group follows it up, by at

least a nod of acceptance. He thus achieves some satisfaction and feels encouraged to express his thoughts and feelings again. Direct questions are avoided as far as possible in order to avoid demand on withdrawn patients which will make them feel uncomfortable. A question may, however, occasionally be directed to a patient who seems to wish to speak but cannot find the courage or the opportunity.

If no response from patients is forthcoming the therapist or psychologist may make a statement expressing some aspect of the feeling conveyed to him by the music. This will often be sufficient to start some discussion and is felt to be preferable to questioning or otherwise indicating expectation from patients. If no spontaneous response can be obtained it is deemed wiser to continue with the music rather than create or prolong any tension or arouse feelings of discomfort in patients.

It has been considered important for our purposes that patients' verbal responses are spontaneous and reflect their own feeling or thinking. Care is taken, therefore, not to precondition them before playing the music, particularly as to what kind of feeling it is expected to arouse. Some will look for clues to ensure a "correct" comment. Equal acceptance is given to positive and negative expressions and in general an effort is made to avoid giving any impression of correct or incorrect responses or of any one feeling in regard to a selection as being the only appropriate one. Every effort is made to encourage independent feeling and expression on the patients' part. The roles of the therapist and the psychologist are kept to a minimum and are felt to be chiefly useful as a catalytic influence.

## ROLES AND RELATIONSHIPS

Because of his wide range of experience in and knowledge of music, it becomes the duty



of the music therapist to select appropriate music and programs for these sessions. He may be influenced in his selection by suggestions from the psychologist, the psychiatrist and the patients. He tries to select the numbers according to his musical and therapeutical experience. The attending psychologist, or psychiatrist, discusses with the therapist the varied effects on the patients. The music therapist has the active co-operation of psychiatrists and psychologists on the hospital staff. He is a part-time member of the staff and cannot follow the daily changing details in the patients' lives. Therefore, we feel the presence of a psychologist who is familiar with the background, problems and behaviour of the patients is important. He may be able to observe the patients while the therapist is busy with mechanical matters of conducting the session. He may be able to understand and possibly interpret silent and vocal reactions to music and ensuing discussion. At first we felt that the psychologist should be a silent observer, but we have learned that he can be used to much greater advantage by being a participant-observer.

An atmosphere of permissiveness and equality is thought to be most likely to foster our chief aims of expression of feelings and socialization. The roles of the music therapist and the psychologist are therefore conceived as those of members rather than leaders in the group. They strive to be as non-authoritarian as possible, and no discipline is exerted in the group unless absolutely necessary. Only incidental value is placed on acquiring knowledge, but any verbal expression on the part of any patient is accepted. In other words, it is hoped to develop a normal pleasant social group devoid of hospital or classroom atmosphere in which each person can feel free to express his feelings and opinions as an equal.

After each session there is a discussion between the music therapist and the psychologist. The relation of the music to the emotions produced and the type and amount of group interaction is discussed. Reaction, or lack of it, on the part of specific patients is considered. If special problems arise, the psychiatrist is consulted for further comments or suggestions. The psychiatrist ordinarily plays no direct part in the sessions. He may attend and participate if he wishes. However, he is kept informed of his patients' progress, or lack of it. His most important role is acting as consultant and adviser.

We have found it quite important that all members of the staff, particularly nurses and nursing attendants, understand the nature and significance of music therapy. With this knowledge they will co-operate much better in encouraging patients to attend music therapy and to talk about it afterwards, while without it they may regard music therapy as another fad.

## GROUP DYNAMICS

There is considerable variety in the type and amount of participation among patients. A few withdrawn schizophrenics have been unable to tolerate the group situation and have been allowed to leave after one or two sessions. Some others, while they never speak in the group, continue to be present willingly and some of these appear to enjoy the sessions. A number who initially were silent have achieved the courage to speak spontaneously occasionally, after a long period of attendance. Other patients begin expressing themselves spontaneously as soon as they join the group. Many are intellectually and emotionally intact enough to enjoy the sessions and express their feelings appropriately from the beginning. Some, however, may hamper

the group by their intellectualization, by dominating the group by their superior knowledge, or by attempting to monopolize the attention of the therapist and psychologist, thereby discouraging others from speaking and preventing any real group feeling.

One might divide all responses which occur into two classes, those which are expressions of feelings and those which are intellectual devices. The former may take the form of statements involving merely liking or disliking the music. Some may name or describe the feeling conveyed by the music. Responses also may describe visual imagery stimulated by the music such as different kinds of landscape, different times of day, and moods of nature. Feeling is usually inherent in these. The second type of response is often a remark or question about the technical aspects of the music—for example, the form of the composition, the name of the composer, the key in which it is written, or the instruments used. Another such device is a personal experience such as having heard something like it, or attended a concert which it recalls, or sometimes a monologue which is not too relevant but which has its beginning in the music played. The motivation behind this kind of response varies. Some are obviously "red herrings" designed to lead the group away from discussion involving feeling. Others are ego-enhancing devices used by more voluble patients who obtain satisfaction from holding the attention of the group or displaying superior knowledge. Some patients can participate only in such intellectualized ways since they maintain themselves habitually by rigid intellectual defences. A few such responses represent a real seeking of information.

In subtle ways the type of response involving feeling is encouraged and the intellectualized type, while never rejected, is not given as much attention. Questions

asking information are always answered, regardless of the motivation. The therapist or psychologist, however, may frame the answer or response in a way which invites some elaboration from the patient on a feeling level or may end with a question involving feeling. It is important to know the patients and to sense the motivation to know how to respond to such remarks and questions. The direction discussions may take is not always predictable. Patients will not as a rule air very personal material in the group, nor is this felt to be desirable. Individual problems on a more superficial level are expressed at times, and problems of human beings in general sometimes are discussed. Religious, political and international affairs have been brought up, and opinions expressed about prominent figures on the national or world scene. This is not discouraged but tolerance and broadmindedness are always given encouragement. Speculation as to the mood or feelings and the personality of the composer sometimes forms part of the discussion. In fact, if no spontaneous discussion arises, the giving of a little information of this sort is sometimes used in an attempt to arouse interest and invite questions or comments. In conversing along these lines patients usually attempt to identify with the composer even though they are unaware that their own feelings are involved in this activity. At times, however, it may lead to more personal observations.

#### OBSERVATIONS

When using records, it has been our experience that the general tone-level—that is, the "loudness"—should be slightly raised most of the time if the group consists mainly of schizophrenic patients, because it takes a greater tone intensity to penetrate the wall of perception and to hold their interest



for any amount of time. At the start in 1952 we operated with a small portable record player of minimum tone clarity. There was much distortion, and volume and colour were lacking. This may have actually alienated some patients rather than have interested them in the medium of music. With the use of a high fidelity player we now can produce more intense responses in patients and enhance their enjoyment in listening. The difference in tone and colour was immediately recognized and commented on by patients.

As with normal listeners, patients will have varying responses to different instruments. In the therapist's opinion, violin or flute may generally have a soothing effect on excited listeners, but may usually not bring a modification of mood in depressed patients. He feels that an ensemble of instruments of more varied tone colour—for instance, piano, violin and cello—has a more decided effect on the patient. Altshuler agrees with this last observation (1). It seems that the variety of instrumental colour is an important factor in keeping the patient's attention for any length of time. Thus modern symphonic music—Stravinsky, Shostakovich, Prokofiev—is more likely to bring about reactions, positive or negative, while records of solo instruments may hold the patient's attention only for a short while. Generally, the more varied and the larger the instrumental group, the more noticeable the impact on the listener. Occasional repetition of selections will usually bring forth new details, which will eventually cling to the mind of the patient, increasing his enjoyment in the particular piece. Familiarity may arouse sentiment and give satisfaction.

We have found a music performance of approximately 40 minutes actual playing time the optimum length. When discussion is vigorous this is more than ample;

when the general mood of the group is less responsive, we extend the time of performance.

Our experience suggests that the most effective participation is obtained with groups of from 6 to 12 patients. The therapist can devote special attention to the individual patient and take suggestions from him as to the kind of music to be used. This gives the patient more of a feeling of active involvement in the program. Listening to music together or singing together will bring forth a feeling of importance and perhaps well-being in a patient, who feels that something is being offered him beyond the usual medical care. As listening is active participation in a common enterprise (often as active as singing or playing), it frequently takes the patient out of his mental seclusion and arouses emotion.

## DISCUSSION

Music therapy as herein portrayed has developed as an empirical therapeutic effort rather than as a planned research project. Since no control groups have been set up and no objective means of evaluation devised, one cannot definitely attribute changes in patients to music therapy exclusive of other aspects of the total therapeutic program in the hospital. We may, however, attempt objectivity in our observation of the group in action and in stating our opinion as to its effects.

While the principle of non-authoritarianism on the part of the therapist and the psychologist has been inherent from the beginning, the mechanics of this role have evolved through a gradual learning process. We feel that we have succeeded to the extent that patients often take the lead in discussion and carry it on among themselves, that a considerable proportion of them join in discussion, and at times may



not agree with an impression expressed by the therapist or the psychologist. They also express negative feelings towards some selections. Complete success in this role-playing has not been achieved, however, since patients at times look to the therapist and the psychologist to initiate and mediate discussion, and tend to address their remarks to them rather than to the group as a whole.

We feel too that some progress in developing social attitudes has been achieved. Some withdrawn patients have initially been scarcely able to tolerate the group situation, but have gradually become comfortable and interested, and some of these have learned to contribute to discussion and express feelings about the music. A few, however, have not progressed beyond mere toleration of the group situation. Some group feeling and friendliness among patients is noticeable, and at times discussion involves a real exchange of ideas and empathy with others. Disagreement also occurs without rancor.

Some voluble, aggressive and even hostile patients, have learned to limit themselves to an appropriate share in discussion, to present their views more reasonably, and to attempt to attune their behaviour to the group atmosphere to a greater extent. This has not always been the case, however. One hostile and domineering female patient, for example, dominated the group as long as she remained in it, and an increase in other patients' contributions and a more relaxed atmosphere soon developed after her discharge from hospital. Another patient was eager to join the group and proceeded to attempt to use it for his own ego-enhancement, but soon withdrew of his own volition when the group failed to receive his opinions with the enthusiasm he expected.

While a very personal level of expression of feeling or discussion of problems seldom

occurs, we feel that this actually gives music therapy a unique and necessary place in the therapeutic program. The medium of music makes it possible for emotion to be recognized and put into words in a less personal and therefore less threatening way. Human problems on a general level are often brought out as a result. Music stimulates feelings and is enjoyable and thus camouflages the therapeutic purpose from patients while it gives pleasure and aids relaxation. For this reason we feel that music therapy benefits some patients who are not yet able to tolerate a more direct approach to their problems, and may prepare the way for other forms of psychotherapy on both an individual and group basis. Mitchell and Zanker feel that music allows the most indirect form of emotional release, and they state in discussing their observations, "Our earlier assumptions that the subverbal response to music possesses advantages in all patients (but especially the most inhibited) over more direct forms of self-expression through art, appear to be justified. This suggests that for some patients a preliminary approach through music might facilitate other therapeutic methods of reaching the unconscious" (15).

The incidental benefits of imparting knowledge of music, of stimulating interest in it and of providing an enjoyable break in the weekly routine have been achieved also to a considerable extent with a majority of patients. Many have broadened their appreciation of music to include classical forms formerly unfamiliar and in some cases distasteful to them. Mitchell and Zanker also report, "As the sessions proceeded education resulted in increased appreciation of the classics whereas other types of music were more immediately appreciated" (15). We feel that this interest may continue in many cases and provide a source of satisfaction and an emotional out-

let which may aid adjustment outside hospital.

To some degree patients, in discussion, are complying with what they feel is expected of them, and are tailoring their expression to the atmosphere which has been largely created by the therapist and the psychologist. We feel, however, that this is a normal and useful social skill which, while not striven for in this situation, does not detract from the therapeutic value of the sessions.

With time given, a great deal will be learned in the field of music therapy. Although we cannot claim unqualified success, we feel that our approach has had beneficial effects. Further experience, with critical and objective observation, may give more insight into the dynamics of the situation, thus making our aims and principles clearer and increasing our skill in the mechanics of this form of therapy.

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## The role of the consultant as a motivator of action

The term consultant is becoming increasingly popular. There are legal consultants, business and industrial consultants, medical and insurance consultants. School systems are converting supervisors into consultants. Some cities and states are hiring mental health consultants.

Is this new emphasis on consultants a change of name only or of function? Undoubtedly, in some situations no change of function is involved, but presumably there is something about the true "consultant" that distinguishes him from others of his profession that are not in the consultant role.

What is a consultant and what does he do? Most simply, he is a specialist in some field of endeavor who helps others solve their business or professional problems. His task is to bring expert knowledge to the

solution of some definite problem. He works for other people, through other people and, if successful, works himself out of a job.

This definition of the role, however, involves two quite specific but different functions. The first is the *knowledge* function, that of analyzing the problem and bringing to it the necessary information and ideas to help solve it. The second is the *motivation* function, that of helping people to define their problems and then to mobilize their own resources for actually carrying out any action program or change. It is usual to think of the consultant mainly in terms of

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Mr. Bowman is research associate at the University of Chicago and chief consultant to Quincy's community youth development project, referred to in this paper.



the knowledge function; actually, the major problems for the consultant seem to be in the area of motivation. If problems could be solved simply by making available the necessary information and knowledge, the consultant's task would be greatly simplified. Perrin Stryker, writing in *Fortune* magazine about the consultant function in industry, says, "Outside consultants simply do not solve the problem. They may be fully qualified and can give endless advice, but they can't tell us how to put *their* knowledge to *our* practical use." He adds that the best test of a consultant is his ability to get company personnel to cooperate in adopting new techniques fitted to their needs—a motivational problem.

Our staff is currently engaged in a 10-year community action research project in which the role of the consultant is of central importance.<sup>1</sup> The purpose is to determine whether social scientists can be effective in improving the mental health and talent development of children when they act as consultants to an entire community over a period of ten years. It is not too difficult to identify problems and outline the needed skills and services, but how can a community be motivated to *want* to improve its services to children? What method can or should be used in trying to promote change? This question is further complicated by the fact that this project was initiated by a university rather than by the community itself. It is obvious that its success hinges on finding answers to the motivation function of the consultant.

This paper will examine the methods of motivation we have used as consultants

and the successes and failures we have experienced.

#### METHODS BASED ON EXTERNAL FACTORS

Consider what frequently happens in the work of a consultant. Perhaps a city government calls in a traffic consultant to help on parking and flow-of-traffic questions. The consultant collects the facts about the city and its traffic, analyzes his data, and on the basis of his knowledge and experience submits a report with his recommendations to the city council. Here his responsibility ends; the knowledge function has been fulfilled to everyone's satisfaction. However, all too frequently the report goes against some local tradition, costs too much or is opposed by powerful interests within the community, and it is filed away with little, if any, action. What approaches can be used if the consultant or others are interested in promoting actual community change?

*Methods of authority.* The speediest way to effect some kinds of change is to command them, but this presumes the existence of the authority to command. By the very nature of his position the consultant usually does not have that authority, and so he must necessarily obtain the support of at least a few influential persons who do have such authority. However, the consultant is not completely empty-handed in this regard, for the informal authority of his own professional status is often highly regarded.

Even though our project staff has no direct authority in the community, informal authority has had its place. The prestige of the university and the professional status of members of the faculty who originally met with community leaders to plan the project were instrumental in getting the project accepted. A university representative spent three months explaining the project to business and professional people,

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<sup>1</sup> For a detailed progress report on this project see Paul H. Bowman and others, *Mobilizing Community Resources for Youth*, Supplementary Education Monographs No. 85, University of Chicago Press, October 1956.

individually and in small groups. The project founders stipulated that a group of citizens representing the boards of the youth-serving agencies should make the decision whether the project should be started in this community or not. Such a group met and constituted themselves the Youth Development Commission, thus providing the base of authority for the project.

This method of authority therefore came into play mostly in the beginning of the project and mostly in dealing with business and professional leaders of the community. Professional prestige proved to be of little use in dealing with citizen groups; in fact, it was at times a barrier that had to be overcome in certain working relationships. The relative youth of some staff members was something of a disadvantage at the beginning, as age and experience are in themselves symbols of prestige.

*Method of emotional contagion.* This is another method commonly used to motivate action. It is used in many mass efforts, such as fund-raising campaigns and advertising, and also in personal contacts between individuals.

In our project we have thus far made little use of mass approaches to the community, even though this may become necessary in later stages of the project. We joined with other agencies in sponsoring "My Name Is Legion," a mental health play on the life of Clifford Beers, that carried an emotional impact to four hundred listeners. Perhaps the speeches given to P.T.A.'s and service clubs might be regarded as mass motivation, but if so it is mild indeed. We sponsored two dinners during the first years for the volunteer workers on teams, where talks were given on the importance of their work.

It is impossible to estimate the effectiveness of the emotional contagion of personal contacts between people associated with the

project and the community at large. The staff, commission members and volunteers have had many contacts with a variety of people, and confidence, or lack of it, engendered through such personal contacts is important.

*Method of reward and punishment.* This method of motivation when used with adults might be compared to a barter system: "I offer you something you want if you will do something I want." This is the basis of many contests and incentive systems as well as of many social and business obligations.

We know of no use of punishments in this project, but rewards in different forms have been tried at times as motivating stimuli. We have offered the reward of academic credit in connection with several of our training courses for volunteers and teachers. This proved to be particularly effective in getting teachers to enter the training course, since they received salary raises for additional training; however, a limited number of these dropped out as volunteers when the course was over, and we have felt that these were likely the ones who were most attracted by the reward of credit. We have also helped the school system obtain several grants of money to undertake experimental programs in testing and in the schooling of talented children. Progress in these areas has, however, been very slow.

A slightly different form of reward is recognition given for work already accomplished. We have attempted to give professional recognition to some by inviting them to the university campus to speak, to others by inviting them to co-author articles and monographs, and to still others by offering scholarships for summer work. This type of reward has proved somewhat more appropriate to the goals we are trying to achieve.

## METHODS BASED ON INTERNAL FACTORS

### *Method of tapping existing motivation.*

The three methods discussed above have several common elements. The goal is rather specific and often predetermined by the consultant. The methods of reaching the goal are outlined in advance by him, in terms of his analysis of community needs. The emphasis is on the arousal of a given motivation.

The fourth method is somewhat in contrast to these and relies on the discovery and utilization of existing motivations rather than on the arousal of new ones. It is aimed at aiding individuals and agencies to assess and clarify their own needs, helping provide avenues for satisfaction of needs, and introducing new types of experience through which existing interests and motivations might be broadened. Here the goal of the consultant may still be predetermined, at least in the general sense of helping to solve a problem, but he has less assurance that his goal will be chosen or achieved. The methods are not outlined in advance but rather developed step by step. Few of the basic decisions are made by the consultant, and he is more concerned with the people and their interaction than with a particular solution.

At the beginning of the third project year the staff felt the need to find more effective methods of motivating action. The outcome of study by the staff was the decision that we should put to full use for one year this method we now refer to as tapping existing motivation. Since then we have tried a variety of ways to discover and put to work the motivations that already exist within the community.

One of these, and the first one in point of time, was merely *helping people to clarify* in their own minds what their needs were.

For instance, we went to the heads of the youth-serving agencies and schools and asked, "What is it you need to be able to do here the kind of job you would like to do?" This resulted in thoughtful and stimulating interviews. Several of these persons later verbalized that this was the first time anyone had come to them without asking for something and that they were surprised and interested. For us it meant that we found some mutual concerns with a number of people and some areas in which we could be of help to them. We also held personal interviews with all of our own volunteers to determine their major interests and needs, and then tried to reorganize the volunteer tasks around these needs. In retrospect we see this as a crucial step in finding a more effective consultant role.

As another way of discovering existing motivations, we used *opinion surveys* to highlight to the community some common needs. For instance, a survey of the meager offerings in adult education and a discussion of these findings in a committee meeting of agency heads stimulated several new efforts. A survey of the recreational needs of youth served to focus attention on the question of youth centers and "hot-rod" clubs, and some definite action resulted. A survey of the number of poor readers brought to light the need for remedial reading in the schools, and one remedial class was formed. A survey of the needs of principals and teachers highlighted the problem of the maladjusted pupil, and a successful workshop was held on this problem.

In addition to trying to clarify and highlight existing needs, we have attempted through *demonstration activities* to acquaint people with various possibilities for action. We ourselves have led parent discussion groups and have held leadership training courses for various agencies; in these we have used movies, recordings and role-play-



ing to demonstrate different approaches to children. A counseling seminar with ministers, two training groups in play therapy, and a number of cases handled successfully for doctors, schools, courts and parents demonstrated the value of therapeutic work. While many of these activities did not directly benefit the experimental group with which we were concerned, we hoped that they might serve to broaden the interest, understanding and concern of the community for its children.

There is some evidence that the demonstration work done in counseling is responsible, at least in part, for the establishment of a mental health clinic. It is likely that some group therapy will be used in the schools in the future, owing to a demonstration of its effectiveness. Recreational clubs set up as a demonstration in two low-income areas have motivated the Scouts to look more closely at the ability of their program to interest these boys. The monthly meetings of a professional advisory committee have demonstrated to agency heads the value of informal, regular contacts among them, and this has since been incorporated into the Welfare Council. The demonstration of "painting picnics"<sup>2</sup> was sufficient to interest an agency in making it a permanent part of its program.

When we discovered a desire to provide services for maladjusted or gifted children, we tried to tap and broaden it by supplying some *new experiences* to the people involved. Two teachers interested in gifted children were sent to a summer workshop on the West Coast, and teachers and administrators have visited other school systems at different times. The executive committee of the Welfare Council visited a city nearby to see other methods of operation. The mental health group visited other cities to observe clinics in operation. A newly elected county judge spent a week observing

the work of other communities in the state. We have hoped that such new experiences might increase the motivation that people have for doing something in their own community in their area of interest.

## DISCUSSION AND EVALUATION

Thus far in this paper I have been describing our consultant activities in terms of the kind of methods used. I should, however, submit our subjective evaluation of their effectiveness, even though we are still in the middle of the project.

To date we feel that the consultant's use of *authority* is most necessary and successful in gaining acceptance of a project from the power structure of the community. It is less effective when used with other groups of people and for other purposes. When successfully used, it can produce rather quick results but does not help create initiative and motivation in others. Stressing the professional status of the consultant or his institution and calling on the support of influential people in the community are two means of utilizing authority.

*Emotional contagion* seems to be most effective as the natural expression of the interest of individuals in their personal contacts with others. Mass attempts to motivate others for youth work require much effort and are of questionable value.

When the consultant uses *rewards*, he should recognize that there is a danger that the rewards will become more important than the goals. It is likely also that those people attracted by rewards will drop their support when the rewards are no longer

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<sup>2</sup> This was a weekly activity initiated by the staff during summers to stimulate artistic development among young children. Children and adult artists visited local points of interest and painted pictures "for fun," played games, ate lunch and talked—doing together rather than having class.

offered. Thus, rewards are more useful in motivating hard work for a short period than in producing creative and long-term effort. Rewards in the form of sincere recognition for service already rendered seem more effective than as ends to be pursued.

The greatest single resource for community youth work is the interest, love and concern for children already existing in many citizens. The most effective method by which a consultant can help motivate the community, we feel, is by tapping existing motivations—that is, by locating those people who are interested in children and by planning ways to utilize their ca-

pacities. This method moves more slowly and with some confusion, but it is more likely to result in others assuming responsibility and discharging it conscientiously and with imagination. When this method is used, there is often a natural reward to those involved, because they are doing something they enjoy and at the same time something that others need.

Our type of consultant role in helping mobilize a community to action in behalf of its youth may be unique, but the experiences we have had seem to us to hold implications for many types of consultant work. We hope that it can be more adequately studied here and elsewhere.

ALLEN HODGES, Ph.D.

DALE C. CAMERON, M.D.

# Minnesota's community mental health services

Contributions of local mental health facilities are now recognized as an important facet of a preventive psychiatric program. The process of establishing local community mental health programs in rural areas presents unique problems, particularly in sparsely populated areas. Geographically, Minnesota's population is almost equally divided between urban and rural. According to the 1950 census, 55.7% of 3,148,000 Minnesotans reside in rural areas.

As to available out-patient psychiatric services, less than 8% of these services are located in rural areas although over half of the population resides in rural localities.<sup>1</sup> This was the challenge to an integrated statewide mental health program in 1955.

## HISTORY OF MINNESOTA'S OUT-PATIENT PROGRAM

Records reveal that as early as 1920 a child guidance clinic was proposed for the Minneapolis-St. Paul metropolitan area. In 1923-24 through the initiative of Dr. Arthur Hamilton, then chief of psychiatry at the University of Minnesota, a demonstration child guidance clinic was established under

Dr. Hodges is psychological consultant on community mental health services and Dr. Cameron is medical director of the Minnesota Department of Public Welfare.

<sup>1</sup> A. K. Bahn and V. D. Norman, "Out-Patient Psychiatric Clinics in the United States", Washington, National Institute of Mental Health, 1956. (Mimeographed)



sponsorship of the Commonwealth Fund and the National Committee for Mental Hygiene. The impetus of this demonstration clinic cannot be minimized, for as a direct consequence three additional out-patient child guidance clinics evolved. In 1924 the Wilder Child Guidance Clinic was established in St. Paul under sponsorship of the Wilder Foundation. In 1924 the Minneapolis Public Schools sponsored a child guidance clinic open to all children of the Minneapolis area. In 1924 a traveling child guidance clinic sponsored by the University of Minnesota operated in Duluth and Mankato; this traveling clinic, while short-lived (1924-25), laid the groundwork for future developments.

In 1938 Duluth established a permanent out-patient clinic under the sponsorship of the Junior League. The city of Rochester and Olmsted County financed an out-patient facility in 1948. Additional child guidance clinics were established in the Minneapolis-St. Paul area in 1950 by the Washburn Foundation and in 1954 by the Hamm Foundation.

Until 1950 out-patient psychiatric services were primarily the concern of private organizations. From 1950 to 1952 the state government established four out-patient clinics, two of them in rural areas. No further developments occurred until 1957.

#### COMMUNITY MENTAL HEALTH SERVICES ACT OF 1957

Under joint sponsorship of the Minnesota Association for Mental Health and the State Department of Public Welfare, the 1957 legislature enacted a Community Mental Health Services Act patterned after the existing New York legislation. In broad language, a state grant-in-aid program was inaugurated, providing up to 50% of opera-

tional costs for community mental health services. Four distinct programs were authorized under this act:

- Establishing new community mental health services.
- Enabling a local community to purchase psychiatric services from a public or private agency.
- Expanding already existing community services.
- Transferring current totally state supported clinics to local community operation.

#### CURRENT TRENDS

One of the most encouraging outgrowths of this act during its first six months of existence is the spontaneous rural interest. Under provisions of this act, 50,000 is the minimum population recommended for the establishment of an all-purpose community clinic. With approximately 15,000 to 18,000 residents in a typical rural Minnesota county, it has been necessary for counties to unite and develop intercounty cooperation to provide the necessary population base (as shown in Table 1). Grants for the establishment of two mental health centers serving 11 rural counties have been made (Willmar and Crookston). Fourteen additional counties have indicated intent to establish, cooperatively, three rural mental health centers. Two larger counties, each having the necessary population, have received grants under the state aid program (Rochester and Austin). As this is written—during the first six months of the grant-in-aid program—a third of Minnesota's 87 counties are planning local community mental health services.

Another gratifying outgrowth of this act has been the county government's willingness to support financially local out-patient

TABLE 1

LOCATION	NAME OF CLINIC	NUMBER OF COUNTIES SERVED	POPULATION SERVED **	TYPE OF GRANT	SOURCE OF LOCAL FUNDS
Grants made 7/1/57-1/1/58	Duluth	1 *	104,511	Expansion of services	Voluntary
	Duluth Mental Hygiene Clinic				
	Rochester	1	50,008	Re-establishment of previous center	Taxes and voluntary contributions
	Rochester-Olmsted Co. Counseling Clinic				
	Austin	1	47,317	New facility	Taxes
Applications approved but funds not available	Willmar	3	66,526	New facility	Taxes
	Willmar Mental Health Center				
	Crookston	8	105,228	New facility	Taxes
	Crookston Northwestern Mental Health Center				
Localities indicating interest in developing local programs	Minneapolis	City	521,718	Expansion of services	Private Foundation
	Minneapolis Washburn Memorial Clinic				
	St. Paul	City	311,349	Expansion of services	Private Foundation
Localities indicating interest in developing local programs	Alexandria	7	98,592	Proposed new facility	Taxes (planned)
	Alexandria Hamm Memorial Psychiatric Clinic				
	Albert Lea	4	101,756	Transfer of state clinic to local operation	Taxes (proposed)
Localities indicating interest in developing local programs	Fergus Falls	3	110,845	Transfer of state clinic to local operation	Taxes (proposed)
	Fergus Falls Mental Hygiene Clinic				

\* Serves primarily Duluth but available to St. Louis County residents.

\*\* Population figures are 1956 estimates by the Minnesota Department of Health.

facilities for their residents. In 28 of the 29 counties currently developing local mental health programs, the entire local financial support is derived from county taxes, the remaining 50% being derived from the state.

#### SUMMARY

The history of the community mental health program in Minnesota demonstrates the lag which has occurred in rural com-

munities. Prior to 1955 less than 8% of out-patient psychiatric facilities were available to 55% of the state's total population. Since the passage of the Community Mental Health Act in April of 1957 one-third of the counties in Minnesota have indicated intent in applying for state grant-in-aid. Two factors appear prominent in current developments: The process of intercounty cooperation and the willingness of local county government units to contribute local financial support.



# Demographic aspects of general paresis

Mental disease, as measured by rates of first admissions to mental hospitals, has been increasing steadily in New York State for many decades. This describes an average result, however, and thereby conceals an opposite trend in certain categories. Chief of these is general paresis, for which rates of first admissions are available since 1911. These rates represent admissions to the civil state hospitals, but since these hospitals include 95% of the admissions with general paresis to all mental hospitals in New York State, public and private, they determine the trend.

Prior to 1920 first admissions with general paresis numbered from 700 to 900 annually and represented approximately 13% of all first admissions. Despite a continuous growth of population, the number of such first admissions fluctuated little up to

1930 and actually decreased subsequently, reaching a minimum after 1950. In conjunction with significant increases in other groups of psychoses, general paresis decreased after 1920 to 2% of the total first admissions.

Table 1 provides smoothed annual rates of first admissions with general paresis for every second year beginning with 1912. The rates were derived from a 3-year moving average. The average annual rate for 1912, for example, is based upon first admissions with general paresis from 1911 to 1913 inclusive.

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Dr. Malzberg is the principal research scientist for the Research Foundation for Mental Hygiene, Albany, N. Y., and for the New York State Department of Mental Hygiene. His investigation was supported by a research grant from the National Institute of Mental Health.

TABLE 1

*Average annual rates of first admissions with general paresis to all New York civil state hospitals, per 100,000 population, 1912 to 1955*

FISCAL YEAR	MALES	FEMALES	TOTAL	FISCAL YEAR	MALES	FEMALES	TOTAL
1912	12.0	4.0	8.0	1936	12.1	3.5	7.8
1914	13.2	3.2	8.2	1938	11.1	3.4	7.3
1916	13.8	3.4	8.6	1940	10.3	3.4	6.9
1918	14.0	3.6	8.8	1942	9.5	3.1	6.2
1920	13.2	3.0	8.1	1944	8.4	2.8	5.5
1922	12.6	2.9	7.7	1946	7.1	2.3	4.6
1924	12.1	2.8	7.8	1948	5.2	1.8	3.4
1926	11.5	2.9	7.2	1950	3.8	1.4	2.6
1928	11.6	3.0	7.3	1952	2.5	1.2	1.8
1930	11.4	3.1	7.3	1954	1.8	0.8	1.3
1932	12.1	3.4	7.8	1955	1.4	0.5	1.0
1934	12.3	3.4	7.8				

Among males the rate rose from 12.0 per 100,000 population in 1912 to 14.0 in 1918. The rate decreased to 11.4 in 1930, then rose to 12.3 in 1934. But since 1934 the rates have decreased without interruption to a minimum of 1.4 in 1955.

Rates for females were at a lower level,

but the trend was similar to that for males. The rate fell from 4.0 in 1912 to 2.8 in 1924, rose to 3.5 in 1936, and then decreased steadily to 0.5 in 1955. Prior to 1950 male rates exceeded those for females in ratios of 3 and 4 to 1. Currently, rates for males are in excess in the ratio of approximately

TABLE 2

*Average annual standardized\* rates of first admissions with general paresis to all hospitals for mental disease in New York State*

PERIOD	MALES	FEMALES	TOTAL
1919-21	21.5 $\pm$ 0.51	4.7 $\pm$ 0.24	12.9 $\pm$ 0.28
1929-31	17.7 $\pm$ 0.41	4.4 $\pm$ 0.21	10.9 $\pm$ 0.23
1939-41	12.9 $\pm$ 0.41	4.2 $\pm$ 0.14	8.4 $\pm$ 0.19
1949-51	3.2 $\pm$ 0.16	1.8 $\pm$ 0.12	3.0 $\pm$ 0.11

\* Population of New York State aged 15 years or over on January 1, 1920 (in intervals of 5 years) taken as standard.

2 to 1. Male rates of first admissions with general paresis have clearly decreased more rapidly than those for females.

4.7 to 1.8, a decrease of 62%, and a verification of the fact that the rate of general paresis fell more rapidly among males.

A further description of the trend is shown in Table 2. The rates are standardized to remove differences resulting from changes in the age and sex proportions of the general population. The population used as standard was that of New York State aged 15 years or over on January 1, 1920. The rate fell from an annual average of 12.9 per 100,000 in 1919-1921 to 3.0 in 1949-1951. Among males the rate fell in 30 years from 21.5 to 3.2, a decrease of 85%. Among females the rate fell from

## AGE

There were 1,122 first admissions with general paresis during 1949-51 to all hospitals for mental disease in New York State. Two-thirds of the admissions were within the age range 35 to 59. There was a sex difference in this respect, females being in relative excess at ages under 40. The average age at first admission was 51.4 for males, 47.5 for females, and 50.3 for both sexes.

TABLE 3

*First admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, classified according to age*

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 POPULATION		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
10-14	5	1	6	0.6	0.3	0.5	0.4	0.1	0.2
15-19	-	9	9	-	2.6	0.8	-	0.7	0.3
20-24	5	7	12	0.6	2.1	1.1	0.3	0.4	0.4
25-29	20	15	35	2.6	4.4	3.1	1.2	0.8	1.0
30-34	25	25	50	3.2	7.3	4.5	1.5	1.3	1.4
35-39	67	49	116	8.6	14.3	10.3	4.0	2.6	3.2
40-44	121	51	172	15.5	14.9	15.3	7.3	2.9	5.1
45-49	108	41	149	13.8	12.0	13.3	7.0	2.6	4.8
50-54	123	42	165	15.8	12.3	14.7	8.4	2.8	5.6
55-59	127	39	166	16.3	11.4	14.8	10.2	3.1	6.7
60-64	80	20	100	10.3	5.8	8.9	7.8	1.9	4.9
65-69	50	20	70	6.4	5.8	6.2	6.6	2.4	4.4
70-74	26	13	39	3.3	3.8	3.4	5.4	2.3	3.7
75-84	19	8	27	2.4	2.3	2.4	4.6	1.4	2.8
85 or over	3	1	4	0.4	0.3	0.4	4.8	1.0	2.4
Unasc.	1	1	2	0.1	0.3	0.2	-	-	-
Total	780	342	1122	100.0	100.0	100.0	3.6	1.5	2.5



The average annual rate grew from less than 1 per 100,000 among those under 20 years of age to a maximum of 6.7 at ages 55 to 59 (see Table 3). The rate grew among males to a maximum of 10.2 at ages 55 to 59. The rates were of a lower order among females, but there was a distinct trend in the sex ratio with advancing age. Through ages 60 to 64 the male rates exceeded those for females in an increasing ratio, which reached 4.10 to 1. As with alcoholic psychoses, this may be related to the high percentage of widowers at the older ages. The incidence of general paresis rises significantly in this group.

The average age at first admission with general paresis has risen since 1920. It rose among males from 44.4 years in 1920 to 51.4 in 1950. Among females the average age increased from 45.1 in 1920 to 47.5 in 1950. This was owing to an increase in the proportion of such first admissions aged 60 or over. In 1920 this age group included 8% of male first admissions with general paresis, and in 1950 the corresponding percentage was 23. Among females the percentages grew from 8 to 18.

In 1930 the average annual rates of first admissions among males exceeded those of 1920 at ages 65 or over. At all other ages, however, the rates for 1920 were in marked excess. A similar pattern occurred in 1940, the rates during that period being less than those for 1930 at all ages up to 65. The downward trend was even more marked in 1950, each age group having a lower rate than the corresponding rate for 1940.

Among females the rates for 1920 exceeded those for 1930 through ages 45 to 49. Beyond that age the rates for 1930 were in excess. With some minor fluctuations the rates for 1940 were less than those for 1930 through ages 50 to 54 but were in excess at higher ages. Between 1940 and 1950 the rates decreased significantly

in all but one age group. The rate of decrease was less, however, than the corresponding ratios among males.

## SEX

All statistical studies show that males have higher rates of general paresis than females, though the degree of excess varies. In general the rates for males have decreased more rapidly than those for females, so that the sex ratio has decreased. Since syphilis is the primary cause of general paresis, it appears probable that changing standards of sex mores in recent decades have been a significant factor in reducing the disparity between the sexes in the relative incidence of syphilis.

## ENVIRONMENT

The incidence of mental disease varies geographically within the state. In general, the rate is higher in urban areas. Under the definitions used by the Bureau of the Census in 1940 incorporated places with a population of 2,500 or over were considered urban. All others were classified as rural.

On this basis the average annual rate of first admissions with general paresis in New York State during 1949-51 was 1.4 per 100,000 white population. The urban and rural rates were 1.7 and 0.8 respectively.

These rates are affected significantly by the varying distributions with respect to age and sex. Therefore, standardized rates were computed, based upon the age and sex proportions of the general population of New York State aged 15 years or over on April 1, 1950. The resulting rates were 2.1 for the urban areas, 1.0 for the rural areas, and an average of 1.9 for the entire state. New York City had a rate of 2.0 compared with 2.4 for the remaining urban areas, but

TABLE 4

*Average annual rates of first admissions with general paresis to all hospitals for mental disease in New York State, per 100,000 population, 1919-21, 1929-31, 1939-41, 1949-51*

AGE (years)	MALES							
	1919-	1929-	1939-	1949-	b	c	d	d
	21	31	41	51	-	-	-	-
	(a)	(b)	(c)	(d)	a	b	c	a
15-19	0.4	0.4	0.5	-	1.00	1.25	-	-
20-24	1.3	1.2	0.5	0.3	0.92	0.42	0.60	0.23
25-29	6.4	5.7	3.4	1.2	0.89	0.60	0.35	0.19
30-34	20.8	18.2	12.1	1.5	0.88	0.66	0.12	0.07
35-39	39.4	28.6	19.4	4.0	0.73	0.68	0.21	0.10
40-44	45.2	34.1	23.5	7.3	0.75	0.69	0.31	0.16
45-49	42.4	34.0	24.9	7.0	0.80	0.73	0.28	0.17
50-54	35.6	33.4	25.1	8.4	0.94	0.75	0.33	0.24
55-59	28.1	23.6	20.1	10.2	0.84	0.85	0.51	0.36
60-64	23.4	19.3	16.4	7.8	0.82	0.84	0.48	0.33
65-69	10.8	13.0	15.3	6.6	1.20	1.18	0.43	0.61
70-74	1.5	5.8	8.9	5.4	3.87	1.53	0.61	3.60
75 or over	1.1	5.1	6.8	4.6	4.64	1.33	0.68	4.18

AGE (years)	FEMALES							
	1919-	1929-	1939-	1949-	b	c	d	d
	21	31	41	51	-	-	-	-
	(a)	(b)	(c)	(d)	a	b	c	a
15-19	0.4	0.4	0.9	0.7	1.00	2.25	0.78	1.75
20-24	1.3	0.9	0.7	0.4	0.69	0.78	0.57	0.31
25-29	2.8	2.4	2.4	0.8	0.86	1.00	0.33	0.29
30-34	5.4	4.0	4.8	1.3	0.74	1.20	0.27	0.24
35-39	7.9	7.5	6.7	2.6	0.94	0.89	0.39	0.33
40-44	9.1	8.6	7.0	2.9	0.94	0.81	0.41	0.32
45-49	9.0	8.1	6.5	2.6	0.90	0.80	0.40	0.29
50-54	7.9	8.2	6.1	2.8	1.04	0.74	0.46	0.35
55-59	4.3	5.7	5.9	3.1	1.33	1.04	0.53	0.72
60-64	1.4	3.7	5.7	1.9	2.64	1.54	0.33	1.86
65-69	0.6	3.5	3.5	2.4	5.83	1.00	0.69	4.00
70-74	-	1.0	2.3	2.3	-	2.30	1.00	-
75 or over	-	1.0	1.8	1.4	-	1.80	0.78	-

TABLE 5

*Average annual rates of first admissions with general paresis, per 100,000 white population, to all hospitals for mental disease in New York State, 1949-51, classified according to urban-rural environment*

ENVIRONMENT	CRUDE			STANDARDIZED *		
	Males	Females	Total	Males	Females	Total
New York State	2.1 $\pm$ 0.12	0.8 $\pm$ 0.07	1.4 $\pm$ 0.67	2.8 $\pm$ 0.16	1.1 $\pm$ 0.10	1.9 $\pm$ 0.09
Urban	2.4 $\pm$ 0.14	0.9 $\pm$ 0.08	1.7 $\pm$ 0.08	3.1 $\pm$ 0.18	1.2 $\pm$ 0.11	2.1 $\pm$ 0.11
New York City	2.4 $\pm$ 0.18	0.8 $\pm$ 0.10	1.6 $\pm$ 0.10	3.0 $\pm$ 0.22	1.0 $\pm$ 0.12	2.0 $\pm$ 0.13
Other	2.7 $\pm$ 0.26	1.1 $\pm$ 0.16	1.9 $\pm$ 0.15	3.5 $\pm$ 0.33	1.4 $\pm$ 0.20	2.4 $\pm$ 0.19
Rural	1.0 $\pm$ 0.18	0.4 $\pm$ 0.11	0.8 $\pm$ 0.11	1.4 $\pm$ 0.24	0.7 $\pm$ 0.17	1.0 $\pm$ 0.14
Farm	0.9 $\pm$ 0.37	0.4 $\pm$ 0.26	0.7 $\pm$ 0.24	**	**	**
Non-farm	1.1 $\pm$ 0.21	0.4 $\pm$ 0.13	0.8 $\pm$ 0.13	1.4 $\pm$ 0.28	0.7 $\pm$ 0.61	1.1 $\pm$ 0.17

\* Population of New York State aged 15 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

\*\* Not computed.

TABLE 6

*Average annual rates of first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, per 100,000 white population, classified according to age, sex and environment*

AGE (years)	URBAN			RURAL		
	Males	Females	Ratio	Males	Females	Ratio
15-19	-	0.6	-	-	0.8	-
20-24	0.1	0.2	0.50	-	-	-
25-29	0.1	0.1	1.00	1.0	-	-
30-34	0.5	0.4	1.25	-	-	-
35-39	1.4	1.1	1.27	0.9	0.6	1.50
40-44	3.7	1.7	2.18	2.9	1.0	2.90
45-49	5.3	2.1	2.52	1.4	1.2	1.17
50-54	5.9	1.9	3.11	2.3	0.8	2.88
55-59	7.6	2.4	3.17	4.0	2.3	1.74
60-64	7.4	1.6	4.63	2.6	1.1	2.36
65-69	4.7	1.5	3.13	2.6	1.3	2.00
70-74	5.2	1.8	2.89	0.9	-	-
75 or over	5.3	0.8	6.63	-	-	-



TABLE 7

*Average annual rates of first admissions with general paresis, to all hospitals for mental disease in New York State, 1949-51, per 100,000 white population. classified according to age and environment*

AGE (years)	MALES			FEMALES		
	Urban	Rural	Ratio	Urban	Rural	Ratio
15-19	—	—	—	0.6	0.8	0.75
20-24	0.1	—	—	0.2	—	—
25-29	0.1	1.0	0.10	0.1	—	—
30-34	0.5	—	—	0.4	—	—
35-39	1.4	0.9	1.56	1.1	0.6	1.83
40-44	3.7	2.9	1.28	1.7	1.0	1.70
45-49	5.3	1.4	3.79	2.1	1.2	1.75
50-54	5.9	2.3	2.57	1.9	0.8	2.38
55-59	7.6	4.0	1.90	2.4	2.3	1.04
60-64	7.4	2.6	2.84	1.6	1.1	1.45
65-69	4.7	2.6	1.81	1.5	1.3	1.15
70-74	5.2	0.9	5.78	1.8	—	—
75 or over	5.3	—	—	0.8	—	—

the difference is not significant. There were too few first admissions with general paresis from the farm population to provide a standardized rate, but it is not likely that the incidence differed significantly from that for the non-farm population.

In general, general paresis, as measured by rates of first admissions, is more frequent among the urban populations. The relative difference between males and females increased significantly in urban areas with advancing age. A corresponding trend cannot be established in rural areas because of random fluctuations in rates, resulting from small numbers of such admissions.

## MARITAL STATUS

The rate of first admissions with general paresis varies in relation to marital status.

The rate was lowest among the married—1.4 per 100,000. It rose to 1.8 among the single and to 3.3 among the widowed. The rates were highest among the separated, 9.1, and the divorced, 8.3. Males had higher rates than females in each marital category.

The several marital groups differ widely in their composition with respect to age and sex proportions. Hence, Table 8 includes standardized rates, the standard population being that of New York State aged 15 years or over on April 1, 1950. It is evident that the rate is lowest among the married and highest among the separated and divorced. There was a marked relative increase in the rate for the unmarried. The sex difference in rates is relatively greatest among the single.

Marriage acts selectively. In dementia praecox the selection is based largely upon

TABLE 8

*Rates of first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51 per 100,000 white population, classified according to marital status*

MARITAL STATUS	CRUDE RATES *			STANDARDIZED RATES **		
	Males	Females	Total	Males	Females	Total
Single	2.6 ± 0.30	0.8 ± 0.17	1.8 ± 0.18	6.3 ± 0.46	1.2 ± 0.21	3.7 ± 0.26
Married	2.1 ± 0.17	0.8 ± 0.10	1.4 ± 0.10	1.7 ± 0.15	0.7 ± 0.10	1.2 ± 0.09
Widowed	7.0 ± 1.15	2.1 ± 0.37	3.3 ± 0.40	4.0 ± 0.87	2.4 ± 0.40	3.2 ± 0.40
Separated	14.8 ± 3.01	5.0 ± 1.47	9.1 ± 1.52	11.0 ± 2.60	4.1 ± 1.33	7.4 ± 1.37
Divorced	15.4 ± 3.67	3.9 ± 1.44	8.3 ± 1.66	11.8 ± 3.22	3.4 ± 1.34	7.4 ± 1.57

\* Based upon corresponding general white population aged 15 years or over.  
\*\* Population of New York State aged 15 years or over on April 1, 1950 (intervals of 5 years) taken as standard.

inherent personality characteristics. There is a different kind of selection, however, in connection with general paresis. The unmarried include an unknown proportion who have developed a syphilitic disease and are therefore either deterred from or limited in their opportunities for marriage. The married benefit, in general, from the stabilizing influences of matrimony. In addition, syphilitic mental diseases remain low in frequency among the married because those who have developed such diseases are likely to have shifted previously to the categories of separated and divorced.

Unlike those with alcoholic psychoses, first admissions with general paresis show no trend in the ratio of rates among the single and the married in relation to advancing age (see Table 9). This is owing, in part, to the fact that maximum rates of such psychoses occur at a later age among the married than among the single. The

widowed had a higher rate than the married. Widows, in fact, had a higher rate than unmarried females.

### ECONOMIC STATUS

First admissions to mental hospitals are defined as follows with respect to economic status: "Dependent means lacking in the necessities of life or receiving aid from public funds or persons outside the immediate family. Marginal means living on earnings but accumulating little or nothing, being on the margin between self-support and dependency. Comfortable means having accumulated resources sufficient to maintain self or family for at least four months."<sup>1</sup>

On this basis, white first admissions with general paresis during 1949-51 were classified as follows: dependent, 22.4%; marginal, 63.6%; comfortable, 11.1%. This distribution approximates closely that for the alcoholic psychoses but includes a significantly lower percentage in the comfortable class than do the manic-depressive or involutional psychoses.

<sup>1</sup> New York State Department of Mental Hygiene. *Statistical Guide*. (12th ed.) Utica, State Hospitals Press, 1943, 52.

TABLE 9

*Ratio of average annual rates of white first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, of the single to the married*

AGE (years)	MALES			FEMALES		
	Single	Married	Ratio	Single	Married	Ratio
15-19	-	-	-	0.7	-	-
20-24	-	-	-	0.1	0.2	0.50
25-29	0.6	0.1	6.00	0.3	-	-
30-34	1.4	-	-	-	0.3	-
35-39	3.0	0.9	3.33	1.4	0.9	1.56
40-44	5.2	3.0	1.73	3.8	0.7	5.43
45-49	9.6	3.1	3.10	1.3	1.5	0.87
50-54	15.0	2.7	5.56	2.8	0.8	3.50
55-59	21.1	4.1	5.14	0.8	2.3	0.34
60-64	10.2	4.6	2.22	1.0	0.7	1.43
65-69	12.1	2.4	5.04	-	1.1	-
70-74	4.6	2.7	1.70	3.0	1.1	2.73
75 or over	7.2	1.4	5.14	-	-	-

TABLE 10

*Average annual rates of white male first admissions \* with general paresis to all hospitals for mental disease in New York State, 1949-51, per 100,000 of selected occupational groups*

OCCUPATION	AGE (YEARS)									
	Total	18-19	20-24	25-29	30-34	35-44	45-54	55-59	60-64	65 or over
Professional, technical etc.	1.1	-	-	-	-	1.2	1.7	4.0	3.8	-
Farmers and farm managers	1.4	-	-	-	-	-	3.3	-	7.0	-
Managers, officials, etc.	1.3	-	-	-	-	0.9	2.3	1.7	1.6	1.9
Clerical and kindred workers	1.6	-	-	-	0.8	1.6	3.3	2.9	2.1	7.1
Service workers, except private household	5.3	-	-	-	-	5.2	6.4	11.4	13.1	3.5
Laborers, except farm and mine	10.5	-	-	1.2	2.7	9.1	22.1	34.4	7.9	11.4
Total labor force*	3.4	-	0.1	0.3	0.4	2.7	5.6	8.4	8.7	10.6

\* Aged 14 years or over.



Rates of first admissions cannot be computed on this basis, however, because of the lack of a corresponding classification of the general population. We may approximate such rates by considering occupational groups, since economic status varies with occupation.

The census of 1950 classified the employed population by age and occupation. In classifying the first admissions according to occupation, use was made of the guide prepared by the Bureau of the Census. There is undoubtedly some degree of misclassification, since we cannot be certain that census enumerators and hospital staff always classified in the same manner. Nevertheless, the rates vary to such a degree as to suggest reliability of the differences.

Table 10 gives average annual rates of first admissions with general paresis among selected occupational groups of white males. Some groups, such as the professional, belong to a high economic category. Others,

such as laborers, belong to a lower economic class. The average rate for the total male labor force was 3.4 per 100,000. The professional group had a rate of 1.1, whereas laborers had a rate of 10.5. Service workers (barbers, janitors, waiters and similar groups) had a rate of 5.3. The managerial group had a rate of 1.3; farmers and farm managers, 1.4; and clerical workers, 1.6. There is a definite trend, the rate of first admissions with general paresis being a minimum at the highest economic level and rising to a maximum in the laboring group. With some minor fluctuations this pattern is repeated in each age group.

Occupational statistics for females are not so significant as those for males, since a large proportion of females are not in the labor force. Nevertheless, some significant differences appear in Table 11. White females engaged in professional or technical pursuits had an average annual rate of 0.2 per 100,000. Clerical workers also had a rate of 0.2. The highest rate,

TABLE 11  
*Average annual rates of white female first admissions \* with general paresis to all hospitals for mental disease in New York State, 1949-51, per 100,000 of selected occupational groups*

OCCUPATION	AGE (YEARS)									
	Total	18-19	20-24	25-29	30-34	35-44	45-54	55-59	60-64	65 or over
Professional, technical, etc.	0.2	-	-	-	-	-	-	2.2	-	-
Clerical and kindred workers	0.2	-	-	-	-	0.3	0.4	3.8	-	-
Private household workers	3.3	-	-	-	-	5.8	6.0	4.0	4.2	-
Service workers, except private household	1.9	-	-	-	-	5.7	2.8	-	-	-
Total labor force*	3.5	2.7	0.2	0.2	1.2	3.8	5.4	9.0	7.4	14.8

\* Aged 14 years or over.

3.3, occurred among private household workers (domestic servants).

It is clear therefore that, in general, rates of first admissions are low in occupations that rank high in the economic scale and are highest at the other end of the economic scale. This is undoubtedly associated with a further class and economic differentiation in the spread of syphilis.

## EDUCATION

The census of 1950 classified the general population according to degree of formal education. This was defined as the highest grade completed. For our purposes we began at age 25, since formal education may be assumed to have been completed by this age. First admissions with general paresis were classified similarly according to degree of education. The reporting with respect to highest grade included so large a proportion of unascertained cases, however, that it was necessary to use broad classes: no education, elementary school, high school, college. First admissions who could neither read nor write were included with those having no education.

Crude rates of first admissions with general paresis are summarized for the white

population in Table 12 according to degree of education. There is an inverse relation, the rates decreasing from a maximum of 7.1 per 100,000 among those with no education to a minimum of 0.7 among those with a college education. Rates were higher for males than for females, but each sex showed the same inverse relation between degree of education and rate of first admissions. Among males the rate decreased from 12.4 to 1.2 with advancing degrees of education. Among females the corresponding rates were 3.0 and 0.2 respectively.

Age specific rates of first admissions are shown in Table 13. With but a few minor exceptions those with no education had higher rates of first admissions than each of the other educational groups in the several age classes. Similarly, those with some degree of elementary education exceeded those with a high school or college education, and the high school group, in turn, exceeded the college group.

It is clear therefore that the rate of first admissions with general paresis varies inversely with the degree of education. But does this imply association or causation? Those with a low degree of education include a significantly higher percentage of

TABLE 12

*White first admissions aged 25 years or over with general paresis to all hospitals for mental disease in New York State, 1949-51, classified according to degree of education*

DEGREE OF EDUCATION	NUMBER			AVERAGE ANNUAL RATES PER 100,000 OF CORRESPONDING POPULATION		
	Males	Females	Total	Males	Females	Total
None	50	16	66	12.4 ± 2.04	3.0 ± 0.88	7.1 ± 1.02
Elementary school	226	97	323	4.4 ± 0.34	1.8 ± 0.16	3.0 ± 0.20
High school	80	43	123	1.8 ± 0.23	0.8 ± 0.14	1.2 ± 0.13
College	25	1	26	1.2 ± 0.28	0.2 ± 0.13	0.7 ± 0.16

TABLE 13

*Rates of first admissions among white first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, per 100,000 of corresponding population, classified according to age and degree of education*

MALES										
DEGREE OF EDUCATION										
AGE (years)	None (a)	Elementary school (b)	High school (c)	College (d)	a b	a c	a d	b c	b d	c d
25-29	—	0.8	0.2	—	—	—	—	4.00	—	—
30-34	10.4	0.9	0.2	—	11.56	52.00	—	4.50	—	—
35-39	—	2.5	1.0	0.7	—	—	—	2.50	3.57	1.43
40-44	6.4	4.6	2.6	3.2	1.39	2.46	2.00	1.77	1.44	0.81
45-54	11.7	6.4	3.4	1.0	1.83	3.44	11.70	1.88	6.40	3.40
55-64	19.0	5.9	3.3	2.9	3.22	5.76	6.55	1.79	2.03	1.14
65-74	9.5	2.6	3.3	4.3	3.64	2.88	2.21	0.79	0.60	0.77
75 or over	8.9	2.1	2.9	—	4.24	3.07	—	0.72	—	—

FEMALES										
DEGREE OF EDUCATION										
AGE (years)	None (a)	Elementary school (b)	High school (c)	College (d)	a b	a c	a d	b c	b d	c d
25-29	—	—	0.1	—	—	—	—	—	—	—
30-34	8.6	0.5	0.2	0.4	17.20	43.00	21.50	2.50	1.25	0.50
35-39	6.7	1.6	0.6	—	4.19	11.17	—	2.67	—	—
40-44	—	2.2	1.6	—	—	—	—	1.38	—	—
45-54	6.3	2.3	1.2	—	2.74	5.25	—	1.92	—	—
55-64	2.2	2.2	2.0	—	1.00	1.10	—	1.10	—	—
65-74	2.2	1.5	0.3	—	1.47	7.33	—	5.00	—	—
75 or over	1.9	0.8	—	—	2.38	—	—	—	—	—

foreign-born than those with higher degrees of education. They also include a higher percentage in dependent economic circumstances. Both nativity and economic status are related to the differential incidence of mental disease. Thus, low degrees of formal education are related indirectly to high

rates of first admissions with general paresis, through association with other social factors, primarily migration and economic status.

#### RACE

Racial comparisons of the incidence of general paresis in New York State must be



limited primarily to the white and Negro populations. These are the only racial aggregates that are described in sufficient detail in the census of population.

There were 475 Negro first admissions with general paresis during the 3-year period 1949-51, for an average annual rate of 17.2 per 100,000 Negroes. The rate rose, in general, with advancing age to a maximum of 55.4 at ages 55 to 59 (see Table 14). Among males the rate grew to a maximum of 89.6 at ages 55 to 59, with an average annual rate of 24.8 for all male Negroes. Among females the rate rose to a maximum of 25.0 at ages 50 to 54, with an average

rate of 10.8 for all female Negroes. The male rate exceeded the female rate in the ratio of 2.3 to 1. The relative excess of the males grew from 12% at ages 20 to 24 to almost 300% at ages 55 to 59.

Between 1930 and 1940 the average annual rate of first admissions with general paresis grew among Negroes from 25.0 to 33.9. Between 1940 and 1950, however, there was a significant decline to 17.2, a decrease of 49%. The decrease occurred in all age intervals. In general, though the rates for males exceeded those for females, the former declined more rapidly during the decade. Between ages 25 and 55 the rates

TABLE 14

*Negro first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, classified according to age*

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
10-14	3	1	4	1.0	0.6	0.8	3.4	1.1	2.2
15-19	-	-	-	-	-	-	-	-	-
20-24	4	5	9	1.3	3.1	1.9	3.8	3.4	3.6
25-29	16	14	30	5.1	8.6	6.3	11.9	8.1	9.7
30-34	19	19	38	6.1	11.7	8.0	16.0	12.1	13.7
35-39	45	32	77	14.4	19.8	16.2	38.4	21.1	28.6
40-44	63	25	88	20.1	15.4	18.5	61.5	20.7	39.4
45-49	37	13	50	11.8	8.0	10.5	41.1	13.1	26.4
50-54	45	18	63	14.4	11.1	13.3	64.5	25.0	44.4
55-59	40	11	51	12.8	6.8	10.7	89.6	23.2	55.4
60-64	15	5	20	4.8	3.1	4.2	50.4	14.1	30.7
65-69	17	8	25	5.4	4.9	5.3	78.1	27.1	48.8
70-74	5	5	10	1.6	3.1	2.1	41.6	30.0	34.9
75-84	3	4	7	1.0	2.5	1.5	38.6	24.7	31.8
85 or over	1	1	2	0.3	0.6	0.4	66.7	33.0	44.1
Unascert.	-	1	1	-	0.6	0.2	-	-	-
Total	313	162	475	100.0	100.0	100.0	24.8	10.8	17.2

TABLE 15

*Average annual rates of first admissions with general paresis among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
15-19	—	—	—	4.9	2.8	3.8	—	—	—
20-24	3.8	3.4	3.6	3.4	4.3	3.9	1.12	0.79	0.92
25-29	11.9	8.1	9.7	27.9	13.5	19.7	0.43	0.60	0.49
30-34	16.0	12.1	13.7	78.7	20.1	45.7	0.20	0.60	0.30
35-39	38.4	21.1	28.6	91.8	23.3	54.7	0.42	0.91	0.52
40-44	61.5	20.7	39.4	78.0	33.4	55.4	0.79	0.62	0.71
45-49	41.1	13.1	26.4	134.0	35.1	84.1	0.31	0.37	0.31
50-54	64.5	25.0	44.4	143.1	26.7	83.4	0.45	0.94	0.53
55-59	69.6	23.2	55.4	101.1	36.3	67.4	0.89	0.64	0.82
60-64	50.4	14.1	30.7	95.1	65.1	79.4	0.53	0.22	0.39
65-69	78.1	27.1	48.8	119.7	21.0	63.6	0.65	1.29	0.77
70 or over	42.3	29.4	34.4	85.4	13.4	41.2	0.50	2.19	0.83
Total	24.8	10.8	17.2	54.5	10.4	33.9	0.46	0.66	0.51

declined by approximately 50% to 60%. The rate of decrease was less at older ages. Among females the rates declined during the decade by approximately 40% up to age 45. At ages 50 to 64 they declined by smaller amounts and showed increases instead of decreases at ages above 65 years.

The white population had an average annual rate of 1.5 per 100,000 population. Males and females had rates of 2.2 and 0.8 respectively. In 1940 the white population had a rate of 5.8, indicating a decrease of 74% during the following decade, compared with a decrease of 49% among Negroes. Thus, though both whites and Negroes had declining rates of general paresis, the decrease was more rapid among whites, so that the relative excess of Negroes over whites increased during the decade.

The Negro population is relatively younger than the white population, a fact which influences the relative incidence of general paresis. Standardized rates are therefore given in Table 18. The population used as standard with respect to age and sex distributions was that of the State of New York aged 15 years or over on April 1, 1950.

The standardized rate for Negroes fell from 49.4 in 1940 to 26.7 in 1950, a decrease of 46%. The decrease was more marked among males, the rate falling from 77.6 to 38.6, a decrease of 50%. The standardized rate fell by only 36% among Negro females—from 23.4 to 14.9. The rate for males was in excess in 1940 in the ratio of 3.32 to 1. In 1950 the ratio was reduced to 2.59 to 1.

Among whites the standardized rate declined from 7.4 in 1940 to 1.9 in 1950, a

TABLE 16

*Average annual rates of first admissions with general paresis among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
15-19	—	0.6	0.3	0.4	0.8	0.6	—	0.75	0.50
20-24	0.1	0.1	0.1	0.4	0.5	0.4	0.25	0.20	0.25
25-29	0.3	0.1	0.2	2.1	1.7	1.9	0.14	0.06	0.11
30-34	0.4	0.4	0.4	8.6	3.7	6.1	0.04	0.11	0.07
35-39	1.3	1.0	1.2	14.7	5.6	10.2	0.09	0.18	0.12
40-44	3.6	1.5	2.5	20.4	5.6	13.1	0.18	0.27	0.19
45-49	4.5	1.9	3.2	20.2	3.3	12.9	0.22	0.58	0.24
50-54	5.3	1.7	3.4	21.4	5.4	13.7	0.24	0.31	0.24
55-59	6.9	2.3	4.6	17.8	4.0	11.5	0.39	0.58	0.40
60-64	6.4	1.5	4.0	14.8	4.3	9.4	0.43	0.34	0.43
65-69	4.2	1.4	2.8	13.2	3.1	7.9	0.32	0.45	0.35
70 or over	4.0	1.0	2.3	6.6	1.9	4.0	0.61	0.53	0.58
Total	2.2	0.8	1.5	8.8	2.8	5.8	0.25	0.29	0.26

TABLE 17

*Average annual rates of first admissions with general paresis among Negroes and whites to all hospitals for mental disease in New York State, 1949-51, per 100,000 corresponding population*

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
15-19	—	—	—	—	0.6	0.3	—	—	—
20-24	3.8	3.4	3.6	0.1	0.1	0.1	38.00	34.00	36.00
25-29	11.9	8.1	9.7	0.3	0.1	0.2	39.67	81.00	48.50
30-34	16.0	12.1	13.7	0.4	0.4	0.4	40.00	30.25	34.25
35-39	38.4	21.1	28.6	1.3	1.0	1.2	29.54	21.00	23.83
40-44	61.5	20.7	39.4	3.6	1.5	2.5	17.08	13.80	15.76
45-49	41.1	13.1	26.4	4.5	1.9	3.2	9.13	6.89	8.25
50-54	64.5	25.0	44.4	5.3	1.7	3.4	12.17	14.71	13.06
55-59	89.6	23.2	55.4	6.9	2.3	4.6	12.99	10.09	12.04
60-64	50.4	14.1	30.7	6.4	1.5	4.0	7.88	9.40	7.68
65-69	78.1	27.1	48.8	4.2	1.4	2.8	18.60	19.36	17.43
70 or over	42.3	29.4	34.4	4.0	1.0	2.3	10.58	29.40	14.96
Total	24.8	10.8	17.2	2.2	0.8	1.5	11.27	13.50	11.47



TABLE 18

Average annual standardized\* rates of first admissions with general paresis to all hospitals for mental disease in New York State, per 100,000 population, 1949-51 and 1939-41, classified according to race

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	1940	a	1950	1940	a	1950	1940
	(a)	(b)	b	(a)	(b)	b		
Males	38.6 ± 2.36	77.6 ± 4.20	0.50	2.8 ± 0.16	11.9 ± 0.33	0.24	13.79	6.52
Females	14.9 ± 1.33	23.4 ± 2.08	0.64	1.1 ± 0.10	3.4 ± 0.17	0.32	13.54	6.88
Total	26.7 ± 1.32	49.4 ± 2.24	0.54	1.9 ± 0.09	7.4 ± 0.18	0.26	14.05	6.68

\* Population of New York State aged 15 years or over on April 1, 1950 (in intervals of five years) taken as standard.

reduction of 74%, compared with 46% among Negroes. The rate for males decreased by 76%, from 11.9 to 2.8. The rate decreased among white females from 3.4 to 1.1, a decrease of 68%. Thus, as with Negroes there was a relatively greater decrease among males than females. In 1940 the rates for males and females were in the ratio of 3.50 to 1. In 1950 they were in the ratio of 2.54 to 1.

Though the standardized rates of first admissions with general paresis decreased among both whites and Negroes, the relative excess of the Negro rate increased during the decade because of the more rapid decline among whites. In 1940 the Negro rate was in excess in the ratio of 6.68 to 1. This grew to 14.05 to 1 in 1950.

It is clear therefore that there has been progress in the prevention of syphilitic mental disease among Negroes since 1940. Compared to the white population, however, there is still need for greater preventive endeavors. Greater control of syphilis and prompt treatment to prevent subsequent infections of the central nervous system re-

main necessities of a sound program of public health.

Table 19 includes statistics of first admissions with general paresis among several major racial or ethnic divisions of the white population. It is not possible, however, to compute rates of first admissions because corresponding data for the general population are not available. We may note, however, that 20% of all white first admissions with general paresis were Italians, compared with only 6.9% for the Irish. In the case of the alcoholic psychoses, the corresponding percentages were 3.9 and 25.2 respectively. Despite the absence of basic census data showing the numbers of Italian and Irish parentage, it is highly probable that such large differences must be statistically significant.

There were 33 Jewish first admissions with general paresis, or 5.3% of the white total. Jews represented only 1% of all white first admissions with alcoholic psychoses. It is possible to estimate the incidence of general paresis among Jews. It is believed, on the

TABLE 19

*White first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, classified according to race*

RACE	NUMBER			PERCENT		
	Males	Females	Total	Males	Females	Total
Jewish	27	6	33	6.1	3.4	5.3
Irish	29	14	43	6.5	7.9	6.9
Italian	110	15	125	24.8	8.4	20.1
Scandinavian	9	2	11	2.0	1.1	1.8
Slavonic	28	8	36	6.3	4.5	5.8
Other	240	133	373	54.2	74.7	60.1
Total	443	178	621	100.0	100.0	100.0

basis of conservative estimates, that Jews represented 15% of the white population of New York State in 1950.<sup>2</sup> On this basis there were 2,080,000 Jews in New York State and 11,791,000 non-Jewish whites. The average annual rates of first admissions with general paresis were 0.5 per 100,000 Jews and 1.7 per 100,000 white non-Jews. This may be considered a significant difference in view of the fact that the estimate of the Jewish population is almost certainly too low and thereby exaggerates the rate for Jews. While low, in general, it also appears that Jews have a significantly higher rate of general paresis than of alcoholic psychoses.

#### NATIVITY

The average annual rate of first admissions with general paresis in New York State during 1949-51 was 1.1 per 100,000 population for the native white population and 3.1 for the foreign-born whites. For males the rates were 1.5 and 5.2 for the native and foreign-born respectively. For females they were 0.8 and 1.1 respectively.

The rates were influenced strongly by the age distributions of the native and foreign-born. The latter include a smaller proportion of the very young (*i.e.*, under age 20), among whom general paresis is relatively rare. Hence, it is necessary to make exact age comparisons. Table 20 shows that in all but one age group native white males had lower rates than foreign-born white males. Among females, however, the rates were higher for the natives at almost all ages. When standardized on the basis of the age distribution of the general population of New York State aged 15 years or over on April 1, 1950, the rates were 1.8 for the native and 1.9 for the foreign-born whites, a difference lacking statistical significance. On the basis of crude rates the foreign-born white males were in excess in the ratio of 3.47 to 1. On the basis of standardized rates this was reduced to a ratio of 1.20 to 1. Despite the small difference, it might be considered significant in view of the fact

<sup>2</sup> *Yivo Annual of Jewish Social Science*. 10(1955), 282.

TABLE 20

*Average annual rates of first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, per 100,000 white population, classified according to nativity*

AGE (years)	MALES			FEMALES		
	Native	Foreign-born	Ratio	Native	Foreign-born	Ratio
15-19	-	-	-	0.6	2.8	0.21
20-24	0.1	-	-	0.1	1.2	0.08
25-29	0.3	-	-	0.1	-	-
30-34	0.4	-	-	0.4	-	-
35-39	1.6	-	-	1.2	-	-
40-44	3.5	3.9	0.90	1.8	0.5	3.60
45-49	5.1	3.7	1.38	2.2	1.3	1.69
50-54	5.2	5.7	0.91	1.9	1.4	1.36
55-59	5.2	9.7	0.54	2.7	1.9	1.42
60-64	5.1	8.0	0.64	2.1	0.7	3.00
65-69	2.7	5.5	0.49	1.8	1.1	1.64
70 or over	3.2	5.2	0.62	0.6	1.7	0.35

TABLE 21

*Average annual rates of first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, per 100,000 white population, classified according to nativity and parentage*

NATIVITY AND PARENTAGE	CRUDE			STANDARDIZED *		
	Males	Females	Total	Males	Females	Total
Native	1.5 ± 0.11	0.8 ± 0.08	1.1 ± 0.07	2.5 ± 0.17	1.2 ± 0.11	1.8 ± 0.10
of native parentage	1.2 ± 0.13	0.6 ± 0.09	0.9 ± 0.08	2.2 ± 0.22	1.1 ± 0.14	1.6 ± 0.13
of mixed parentage	2.4 ± 0.54	1.4 ± 0.31	1.9 ± 0.26	4.4 ± 0.68	2.2 ± 0.44	3.3 ± 0.40
of foreign parentage	1.9 ± 0.24	0.8 ± 0.15	1.4 ± 0.15	2.8 ± 0.31	1.1 ± 0.19	1.9 ± 0.18
Foreign-born	5.2 ± 0.44	1.1 ± 0.20	3.1 ± 0.24	3.0 ± 0.33	1.0 ± 0.19	1.9 ± 0.19
Total	2.1 ± 0.12	0.8 ± 0.07	1.4 ± 0.07	2.8 ± 0.16	1.1 ± 0.10	1.9 ± 0.09

\* Population of New York State aged 15 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.



# Demographic Aspects of General Paresis

MALZBERG

TABLE 22

*Average annual rates of first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, per 100,000 native white population, classified according to age and parentage*

MALES						
AGE (years)	of native parentage (a)	of mixed parentage (b)	of foreign parentage (c)	$\frac{b}{a}$	$\frac{b}{c}$	$\frac{c}{a}$
15-19	—	—	—	—	—	—
20-24	0.1	—	—	—	—	—
25-29	0.5	—	—	—	—	—
30-34	0.1	1.4	0.5	14.00	2.80	5.00
35-39	2.0	3.4	0.7	1.70	4.86	0.35
40-44	3.7	6.4	2.7	1.73	2.37	0.73
45-49	5.6	8.4	3.3	1.50	2.54	0.59
50-54	4.5	10.5	4.6	2.33	2.28	1.02
55-59	2.6	5.8	9.4	2.73	0.62	3.62
60-64	3.7	9.2	6.7	2.49	1.37	1.81
65-69	1.3	7.1	4.3	5.46	1.65	3.31
70 or over	1.9	4.0	6.0	2.11	0.67	3.16

FEMALES						
AGE (years)	of native parentage (a)	of mixed parentage (b)	of foreign parentage (c)	$\frac{b}{a}$	$\frac{b}{c}$	$\frac{c}{a}$
15-19	0.5	1.5	—	3.00	—	—
20-24	0.1	—	—	—	—	—
25-29	—	0.6	—	—	—	—
30-34	0.5	1.3	—	2.60	—	—
35-39	1.3	3.0	0.6	2.31	5.00	0.46
40-44	2.0	4.1	1.0	2.05	4.00	0.50
45-49	2.0	2.8	2.3	1.40	1.22	1.15
50-54	2.0	2.0	1.7	1.00	1.17	0.85
55-59	2.2	3.4	3.2	1.54	1.06	1.45
60-64	1.2	4.3	3.2	3.58	1.34	2.67
65-69	1.1	3.5	2.5	3.18	1.40	2.27
70 or over	0.4	1.3	0.4	3.25	3.25	1.00

that the rates for the foreign-born males were consistently in excess in all but one age group. The reverse is the case for females, however, the standardized rates

being 1.0 for the foreign-born compared with 1.2 for the natives, rates for the latter being in excess at all ages from 25 to 65.

Since the incidence of general paresis

varies with the degree of urbanization, it is probable that the rates for the foreign-born would be reduced still further if corrections were made for such concentration of population.<sup>3</sup> We must conclude therefore that general paresis, a consequence of syphilis, is at least not significantly greater in incidence among the foreign-born males, and in the case of females is probably less frequent among the foreign-born.

### PARENTAGE

The native white population may be divided into three groups on the basis of parentage. Those of native parentage had an average annual rate of first admissions with general paresis of 0.9 per 100,000 corresponding population. Native whites of foreign parentage had a rate of 1.4. Native whites of mixed parentage (one parent native, the other foreign-born) had a rate of 1.9.

The crude rates are influenced, however, by the differential distributions with respect to age. Almost half of the natives of native parentage were under 20 years of age, compared with less than 10% of those of foreign parentage. Natives of mixed parentage had the highest percentage in the age groups characteristic of general paresis. Therefore the preceding comparisons must be adjusted with respect to age.

The rates were standardized on the basis of the age and sex distributions of the general population of New York State on April 1, 1950 aged 15 years or over. On this basis the average annual rates were as follows: of native parentage, 1.6; of mixed parentage, 3.3; of foreign parentage, 1.9. According to definitions employed by the Bureau of the Census, natives were also considered of mixed parentage if the nativity of one parent was known and the nativity of the other was unknown. Some who were

so classified probably belonged to the other nativity groups. When the nativity of both parents was unknown it was assumed in the preceding comparisons that they were foreign-born. Hence, there is a possibility that some first admissions were classified incorrectly as of foreign parentage.

Nevertheless, the differences in specific age rates of first admissions are so large (see Table 22) that it may be concluded that they point in the correct direction. That is, native whites of native parentage had the lowest rate of general paresis and native whites of mixed parentage had the highest rate. The difference between native whites of native parentage and those of foreign parentage is not statistically significant.

The most striking difference is that between native white males of foreign parentage and those of mixed parentage. Their standardized rates were 2.8 and 4.4 respectively. Males of foreign birth also had a lower rate than natives of mixed parentage. The implication is that those with a uniform social origin as measured by similar backgrounds of nativity are likely to have more closely knit family relations, which is a form of social prophylaxis.

### SUMMARY

1. For several decades there has been a steady, significant decrease in the annual rates of first admissions with general paresis.
2. The rate declined for both males and females, but more rapidly for the former.
3. Males have higher rates of first admissions than females, the relative disparity in such rates increasing with advancing age.

<sup>3</sup> Benjamin Malzberg, "Mental Disease among the Native and Foreign-born White Populations of New York State, 1939-41," *Mental Hygiene*, 59(4, 1955), 545-63.

4. The average age of first admissions with general paresis has risen since 1920 and is owing to an increase in such first admissions aged 60 years or over.

5. General paresis is more prevalent in urban than in rural areas. The excess of the male rate is relatively greater in urban areas and increases with advancing age.

6. General paresis is least prevalent among the married, and the rates are highest among the separated and the divorced. The widowed have higher rates than the married.

7. First admissions with general paresis have higher percentages classified as in dependent or marginal economic status than other groups of mental disorders, such as manic-depressive. Rates of first admissions according to occupational groupings show that those in high economic categories have low rates of general paresis and that those in low economic categories have high rates.

8. The rate of first admissions with general paresis varies inversely with degree of education. Those with no or little formal education have higher rates than those with varying degrees of higher education. The differences are closely associated with differences in economic status.

9. The rate of first admissions with general paresis decreased by almost 50% among Ne-

groes between 1940 and 1950. The rate decreased more rapidly among males than females.

10. This is the first time since the beginning of heavy Negro migration to New York State that the rate of first admissions with general paresis has decreased among Negroes.

11. The rate also decreased among the white population but at a greater rate than among Negroes. As a result the Negro rate exceeded the rate for whites in the ratio of 14.05 to 1, compared with a ratio of 6.68 to 1 in 1940.

12. Jews had a lower crude rate of general paresis than the remaining white population of New York State.

13. It is probable that those of Italian origin had a higher rate of general paresis than the Irish in New York State.

14. Foreign white females had a lower rate of general paresis than native white females. There was no significant difference among males.

15. Native whites of native parentage had a lower rate of first admissions with general paresis than foreign-born whites. They also had lower rates than native whites of either foreign or mixed parentage. The latter had the highest rate.



# Book Reviews

## CURRENT PRACTICES IN MENTAL HOSPITAL ADMINISTRATION

By the American Psychiatric Association  
Mental Hospital Service

Washington, American Psychiatric Association, 1958.

One need only review the contents to know that this is an outstanding collection of articles (previously published in *Mental Hospitals*) by some of the foremost mental hospital administrators of our times. Lest the neophyte gain the impression that this is the answer to mental hospital administration, however, one must pay serious attention to Dr. Overholser's preface, which advises that although "the contents do not completely cover the field, an attempt has been made to deal with essential points in each category." It is the hope of the chairman of the APA committee on certification of mental hospital administrators that the publication may not only prove to be instructive in a field where material is altogether too sparse, but that it will illustrate the varied satisfactions that mental hospital administration as a field has to offer to a number of people.

Granted that a number of articles are profoundly basic (this has been deliberate in order to appeal to all levels of mental hospital personnel), bear in mind that it is not intended to represent the end product in mental hospital administration guidance, for there are a number of problems that are not touched upon. Those that are included are written in excellent fashion, readily comprehensible and, as such, are highly recommended to all those dealing in the mental hospital field. Particularly gratifying are the comprehensive bibliographies at the end of each article, so that ready references are available to all who diligently peruse its contents. Any person displaying

interest in this area, irrespective of his profession, can acquire a wealth of information and insight in plant operation, training programs, public relations, team approach, job definitions—to mention a few is to do an injustice to the others.

From Chapter 1 by Dan Blain through to its termination this small booklet is thoroughly enjoyable and should be required reading for any candidate who intends to pursue this field and particularly for those who anticipate facing the APA committee of examiners on certification of mental hospital administration.—ROBERT S. GARBER, M.D., New Jersey Neuro-Psychiatric Institute.

## PREVENTION OF CHRONIC ILLNESS

Volume I: Chronic Illness in the United States

By the Commission on Chronic Illness

Cambridge, Harvard University Press, 1957. 338 pp.

This first volume of a group of studies by the chronic disease task force gives indication of the tremendous job that has been done and will be done in this study. Although much of the material is not new or startling, the availability of such in textbook form will be of considerable importance, not only to provide an approach to handling such illness but also to assist a variety of individual operations which could benefit from cooperative work. Since the problem of the task force was global, both in numbers and kinds of illnesses, the report contains many generalities but also pulls together material not easily available elsewhere.

Those in the field of mental health might feel that their interests were slighted because the proportion of the material devoted

to mental health does not seem as great as the total problem. The material is clear and succinct but there is very little new about the mental health area either in prevention or in therapeutic needs. To this extent those chapters concerning mental health are valuable mostly in terms of the comprehensive statement of current approaches. The work of this commission is perhaps better spelled out in a chapter entitled "The Emotional Aspects of Chronic Illness." This chapter makes clear the current feelings about the effect of mental health on many other illnesses.

Subsequent volumes will make this series a valuable compendium in an area of medical care which both clinically and economically demands attention.—HENRY H. WORK, M.D., University of California School of Medicine.

## PRINCIPLES OF PERCEPTION

By S. Howard Bartley

New York, Harper & Brothers, 1958. 482 pp.

"It is probable that the person who gets great enjoyment out of his senses—that is, gets pleasure out of the sheer sensuous impact of his surroundings—is in pretty good mental health" (p. 459). Thus concludes Professor Bartley at the end of his investigation of the *scientific* aspects of perception. The book will be disappointing to those for whom "perception" is the current magic word (as "semantics" was not too long ago). For Professor Bartley is an experimental psychologist whose primary field of interest has been vision, and he has little patience with poorly defined terms. He points out that there has been little attempt to agree on definitions, and suggests one of his own which would differentiate between the cognitive and thinking processes on

the one hand and perception on the other:

"That perception is definable is another conclusion. To use the word and save any of its ordinary meaning, the most logical and useful primary procedure is to divide human activity into two vast categories. The first is the behavior that follows closely upon stimulation, a behavior that is immediately available for response to the come-and-go of impingements upon it. The second category includes all activity that succeeds the first—the aftermath and sequel to perceptual response. . . . It is by definition, for example, that perception can be said to be discriminatory" (p. 450).

He reviews in detail the experiments on perception—in such detail, in fact, that the non-experimentalist is apt to become impatient with him. After finishing the book, however, I am convinced that this is a necessary discipline for anyone concerned with perceptual processes. In fact, a strong case might be made for this as required reading for all who have any pretense at professional psychological competency. It should make us more self-conscious in the use of such an emotionally loaded word—make us cautious in its undefined use.

From the standpoint of the general reader one could wish that the last few chapters had been expanded, but Bartley himself would say that he has done about all that the *scientist* can do at this point, that there is already too much speculation on limited facts in the everyday applications of the principles of perception. What he does say, however, suggests some of the almost limitless possibilities of research in this field. The implications for education, psychotherapy, etc., are exciting, to say the least, but the leap is pretty broad that leads from experimentally validated perceptual hypothesis to the practical applications of those theories.

So although he only suggests some of the

more practical aspects of the subject, he lays a pretty firm foundation for the necessary steps to a more secure application and helps us to see the incomplete structure undergirding much of our thinking in this field. The psychotherapist, the mental hygienist and all others dealing with the practical problems of human behavior should have this as a basic reference on their shelves—and turn to it now and then just to refresh their minds on just how *scientific* some of their thinking is.

There are two rather disappointing aspects of the book, however, which should be mentioned in passing. There are a surprising number of misprints in the book (as where a reference to "white mice" comes out "white noise"—and other obvious misspellings). And the author is apparently completely unaware of the existence of the subjunctive. One cannot expect a psychologist to be a grammarian, but the editors should have caught him at least part of the time. And the Harper imprint has usually guaranteed good proofreading. While these flaws do not invalidate the book, they take away some of the pleasure in its reading.—W. EDGAR GREGORY, M.D.,  
College of the Pacific School of Education.

## THE NATURE AND TRANSMISSION OF THE GENETIC AND CULTURAL CHARACTERISTICS OF HUMAN POPULATIONS

Papers presented at the 1956 annual conference of the Milbank Memorial Fund  
*New York, Milbank Memorial Fund, 1957. 143 pp.*

The ten papers in this volume are organized under three headings. The first section, entitled *Factors Influencing the Characteristics of Populations*, includes three papers which raise questions of general interest

with emphasis on the complexity of inter-relationship of the genetic and cultural factors. In the second part, *Identification, Distribution and Fertility of People with Variant Characteristics*, three article reporting on specific studies are preceded by one on the significance of tests in such studies. The third group of papers is entitled *Research on Genetic Factors in Characteristics of Populations*. Here there are three papers on current research problems in these fields.

All articles represent thoughtful efforts to avoid bias, and the authors stress the fact that cultural and genetic forces operate together. Dr. Theodore Dobzhansky, discussing the biological concept of heredity as applied to man, warns that the demonstration that hereditary factors affect a trait does not exclude the possibility that environmental factors contribute, and also that the degree to which hereditary or environmental factors operate will vary according to time, place and material studied. Dr. Gordon Allen points out in discussing the genetic aspects of mental disorder that an hereditary basis for behavioral phenomena may be satisfactorily demonstrated before anatomical correlates can be found and, conversely, the presence of an anatomical or biochemical correlate is not necessarily proof of genetic variation—as in some studies of genetics and schizophrenia.

Related to this statement of Dr. Allen's is a question brought to mind by Dr. Dudley Kirk's paper on the fertility of a gifted group. Could it be that a common factor such as having been reared in a small family contributed to the success of these men as well as to their tendency to produce small families?

It is remarkable that no consideration is given in these papers to the potential contribution here, unwieldy as it may be, of



psychoanalytic thinking. The powerful impact of emotional factors, conscious and unconscious attitudes, etc., goes unremarked except in the broadest cultural terms. The inclusion of one paper on a study proceeding from this direction would have added a valuable dimension. Perhaps such an effort may become part of the extensive twin studies outlined by Dr. Frank Falkner in the final article.—ALICE R. CORNELISON, Yale University School of Medicine.

#### NEW FRONTIERS OF AGING

Wilma Donahue and Clark Tibbitts, eds.  
*Ann Arbor, University of Michigan, 1957. 209 pp.*

*The New Frontiers of Aging* is a comprehensive study of the ever-increasing problems in the care of the older portion of the population. The treatise provides informative and instructive reading, especially for those engaged in social science, social service and the care and rehabilitation of the aged.

This book would be a valuable adjunct to any library. Each chapter, written by a recognized authority in his particular field, supplies many tables of comparative figures, making the book also a very handy and convenient reference tool.

The constantly increasing and widespread adoption of automation in industry has in the last few years added greatly, and will add more so in the future, to the difficulty of the older worker in continuing his employment. This factor is perhaps the most disruptive element that can destroy the morale of the aging person, who is still able to work but deprived of the opportunity of doing so. This problem is masterfully treated in the chapter on automation, which clearly points out the pressing necessity of further study and research.

The areas of present endeavor are fully

explored and new avenues of development and further study are suggested. The interest of the reader is not allowed to wane as each particular facet of the problem is considered in turn.

The Scandinavian countries have always been considered well advanced in social welfare, and the chapter devoted to them affords an interesting glimpse into how they handle the problem of proper and adequate housing for the aged.

As administrative head of a home for the aged housing over 300 men and women I find much in the book that I can advantageously use in working out the problems that daily confront me. And I can highly recommend it to the attention of those who work with and are interested in the welfare of our elder citizens.

Congratulations to both Mr. Tibbitts and Dr. Donahue for their splendid work on *The New Frontiers of Aging*.—MOTHER M. BERNADETTE DE LOURDES, Mary Manning Walsh Home, New York City.

#### YOUTH AND CRIME

Proceedings of the Law Enforcement Institute held in 1955 at New York University  
Frank J. Cohen, ed.

*New York, International Universities Press, 1957. 273 pp.*

This report by a group of socially minded citizens working on pre-adult behavior problems is well worth reading, particularly at this time when there is so much concern about juvenile delinquency.

The focus of the report is how to help our law enforcement agents do a more effective job in coping with youthful offenders. It is emphasized by nearly all speakers that this is a multi-faceted problem, and that the law enforcement officer is only one member of the community team which

must function as an integrated unit if an effective job is to be done. L. Bender, reporting on 20 years' experience with disturbed children at Bellevue Hospital, finds six factors contributing to the problem: Pathological identification resulting from broken homes, disturbed parents, etc.; conflicts resulting from cultural attitudes on the role of male and female in our society; social discrimination because of race, color or creed; learning difficulties; organic brain disease; latent or mild schizophrenia. She also points out that the incidence of hard-core juvenile delinquency has been about the same for the last hundred years and that more research, particularly longitudinal studies, is necessary.

The need for more money for legal, social and psychological facilities and for better integration of these facilities is stressed, as well as a firmer and a less permissive attitude on the part of law enforcement officers.

The former attorney general of New York, the Honorable Jacob K. Javits, was chairman of the New York State Youth Commission, the Honorable Mark A. McCloskey, and the director of the Law Enforcement Institute, Dr. Frank J. Cohen, are to be commended for sponsoring and organizing an institute of this nature. The problem is complex and pressing, and this type of report contributes to the understanding which is necessary for action.—LEWIS I. SHARP, M.D., New York City.

## THE PATIENT AND THE MENTAL HOSPITAL

Milton Greenblatt, Daniel J. Levinson and Richard H. Williams, eds.

Glencoe, Ill., Free Press, 1957. 658 pp.

In recent years it has become increasingly evident that all is not well with our public

mental hospitals. Deutsch pointed out some striking discrepancies in the performance of the hospitals in the 1930's as compared with that in the 1830's and 1840's. Bateman and his colleagues studied the mental hospital as a society and Sewall and the sociologists from Duke University examined some of the standard procedures in the Veterans Administration hospitals. They found that many current practices are, in fact, quite anti-therapeutic and have certainly contributed to the accumulation of chronic patients and the resulting necessity for continual expansion of hospitals.

The present book, which is the edited transcript of a research conference on socio-environmental aspects of patient care in mental hospitals, documents many questionable practices and suggests plans which may lead to correction. It is substantially a report of studies and research going on in the field. There are 49 contributors, representing the disciplines of psychiatry, psychology, social science, anthropology, nursing and biometrics. The book is divided into four sections (each opening with a general statement) dealing with four aspects of care: Organization, therapeutic personnel, the ward and the extra-hospital world. The final chapter summarizes the conference and ongoing efforts in this field from the viewpoint of hospital practice, systematic theory and research. Dr. Harry C. Solomon has contributed a thoughtful foreword.

The book loses a bit in its impact because it is rather too long and contains a number of highly technical statistical papers which will be unintelligible to many readers. Also, to this reviewer, the conference and book would have been improved by contributions by more mental hospital administrators who have actually fought the battle of the budget with the Congress or a legislature. These objections are rather insignificant.

however, in view of the tremendous importance of most of the papers, which report studies and research complete or in progress. The fresh, non-traditional approach of the social scientists as described here has proved to be amazingly fruitful both in developing new ideas and insights and in actually starting new programs of action. It would be discriminatory to discuss the merits and demerits of the various papers, even if space permitted. This reviewer found those dealing with administration and nursing problems most rewarding, which doubtless reflects his own particular interests. Others will find equally provocative material such as that on role images, family relationships and cultural attitudes. The section titled "What Is Therapy and Who Does It" is well worth everyone's attention.

There is a beginning here of a revolutionary period in mental hospital practice. While it has been partially obscured by the explosive advent of drug therapy, the total effect will likely be more far-reaching. The two together may well spell the welcome demise of the state hospital as we know it.

I am sure this volume will be read and re-read and discussed for a long time.—  
GRANVILLE L. JONES, M.D., Little Rock State Hospital.

## THE CHILD IN THE EDUCATIVE PROCESS

By Daniel A. Prescott

New York, McGraw-Hill Book Co., 1957. 502 pp.

*The Child in the Educative Process* describes a 3-year program of child study activities, illustrating its main features in case histories. Dr. Prescott emphasizes the impact of concrete classroom occurrences upon the particular youngster under dis-

cussion, and shows the important role played by the teacher.

His sound understanding of the educative process is demonstrated throughout this volume by the author's sensitivity to such matters as interpersonal relationships, the emotional climate of the classroom and the factor of ego involvement of the individual child. Knowledge gained from the child study program of the Institute for Child Study of the University of Maryland is also discussed.

Dr. Prescott presents his subject in a challenging manner. The reader is confronted with more issues about classroom problems and child development than are ordinarily considered in a single book. The result is that he finds himself involved in a creative reading experience in which he can begin at almost any place in the book and absorb much valuable information.—  
ARTHUR LERNER, Los Angeles City College.

## SCHIZOPHRENIA: SOMATIC ASPECTS

Derek Richter, ed.

New York, Macmillan Company, 1957. 181 pp.

This valuable book is the outcome of a meeting at Ciba Foundation in London for the purpose of reassessing the present knowledge of somatic aspects of schizophrenia. The first of the nine papers appearing in this small volume is one by L. Rees on the physical characteristics of schizophrenia patients. It is followed by one on the interaction of genetic and environmental factors in the causation of schizophrenia by M. Roth. Both of these presentations consider the data of Kallman and the more recent findings of Slater pertaining to the genetic factor in schizophrenia. The influence of the physical status of the patient and the environmental factors which seem



to be of significance in the precipitation of the illness are reviewed critically. The difficulties of a simple generalization in genetic terms are pointed out. D. Hill writes on the use of the electroencephalogram in schizophrenia. Though routine EEG records have been somewhat disappointing, the possibility of using such records in experimental situations and following the administration of known biochemical substances still looks inviting. Throughout these three papers the implication of maturation processes in schizophrenia are entertained.

The biochemical aspects of schizophrenia are covered by D. Richter, endocrine changes by D. E. Sands. The material in these two papers reflects most clearly the difficulty of correlating biochemical data with what is agreed to be a heterogeneous group of conditions. In addition to the influence of the emotional state of the individual on the determinations made, there is the question of whether the findings are of etiologic significance or are only variations which occur as an outcome of the disease.

A paper on the metabolism of recurrent schizophrenia by L. H. Rey reviews principally the works of Gjessing and of Rowntree and Kay. The data, though applicable to a small group of patients, contributes to our knowledge of the biochemical changes undergone by this group. In a paper on the pathological anatomy of the schizophrenias, G. B. David covers quite extensively the literature, which consists largely of negative findings. There are, however, some suggestions of a semi-permanent, histologically demonstrable metabolic dysfunction of the neurohormones of the diencephalon. S. Sherwood presents a comparison of experimental neurophysiological findings to schizophrenia symptoms in his paper on consciousness, adaptive behavior and schizophrenia. His contribution is

provocative and looks optimistically to the future. The final paper—on drug action in schizophrenia by Dr. Stafford-Clark—reviews in part the presently more fashionable toxic theories in the causation of schizophrenia.

In an over-all view of the material presented in this book, there is no doubt that the genetic evidence is impressive. The concept of stress and its implications in terms of physical and/or psychological factors precipitating schizophrenia is emphasized. Though the possible production of a toxic agent resulting from stress in a group of subjects with a specific genetic constitution is inviting, there still remains the consideration of neural organizations and their adaptive capacities.—FRED ELMADJIAN, M.D.  
Worcester State Hospital.

## THE MIND OF THE MURDERER

By W. Lindesay Neustatter

*New York, Philosophical Library, 1957. 232 pp.*

*The Mind of the Murderer* is written for the lay reader. In 16 chapters the author gives accounts of killers he studied directly or through newspaper reports. We meet "Christie—The Hysteric" who strangled numerous women; "Ley—The Paranoiac" who worked for years in a law firm, then entered politics and planned a grisly murder by proxy; "Neville Heath—The Psychopathic Sadist" whose revolting butcheries shocked the British public. The style is descriptive, and Dr. Neustatter includes lengthy transcripts of court proceedings and medical examinations. The appendix gives the entire Homicide Bill recently introduced in England and Wales; under Clause 2 murder convictions can be changed to manslaughter if the killer was suffering from "an abnormality of the mind."

Some of the murderers described in this book clearly suffer from mental illness. But more often than not the psychiatric findings are ambiguous and a judge or jury would have difficulty in applying Clause 2. The author states "there is a lack of objective tests in mental illness to establish a diagnosis, which frequently is a matter of opinion" (p. 186). He purposely avoids analyzing the motives which lie behind the homicides. Perhaps the act of murder itself should constitute an "objective test" of emotional disturbance, and the concern with squeezing criminals into nosologic categories which were established for patients in mental hospitals be abandoned. Indeed, when Dr. Neustatter asks "was he an hysterical psychopath, a schizophrenic, or a plain liar?" (p. 222) he precludes an answer. In these and similar questions the author has scrambled the technical terms used by physicians with words that have differing connotations for the lay reader.

Although his case material is fascinating, Dr. Neustatter's book does not merit a recommendation to the serious students of criminology.—PETER F. OSTWALD, M.D., University of California Medical Center.

## REMOTIVATING THE MENTAL PATIENT

By Otto von Mering and Stanley H. King  
*New York, Russell Sage Foundation, 1957. 216 pp.*

This a timely, well written book soberly pointing up the renewed attack on mental illness, not only by the current chemical and somatic therapies but by the training and stimulation of hospital personnel to create an appropriate milieu that will remotivate the mental patient—even the lobotomy cases and the old, long-time chronically ill. Dr. von Mering, an anthropologist, and Dr.

King, a social psychologist, focus "on the possibilities that exist within the social situation for an improved understanding of the patient and new outlooks for his rehabilitation." They relate some of the courageous and promising attempts to resolve the hospital population situation, despite budget and staff problems, and to reverse the philosophy of pessimism of cure for individuals committed to public mental hospitals. The problems are awesome when one considers that only 40% of patients admitted to state institutions are discharged in a 5-year period, that the average stay is 8 years, and that 27% of all new admissions have senile psychosis or cerebral arteriosclerosis.

The authors point out that the rigidity of social classification of ward patients—"sitters," "onlookers," "doctor chasers"—precludes exploring attitudes toward the treatment of long-term patients. Also, how the term "chronic" alters staff expectation into implicit acceptance of hopelessness, helps patients become unknown entities populating a ward, and supports staff inaction. They point out the varieties of care with such words as "museum ward," "moving ward," "family ward," and the drawbacks.

Interesting chapters, with happy titles, describe ways in which remotivation has been put into practice in a variety of wards and in many different hospitals. The chapter on the habit-training ward points up toilet care as a basic ingredient in changing apathy and discouragement to optimism. The chapter on the house of miracles describes how much can be done with post-lobotomy patients and an orientation program for the relatives, "pushing gently but not shoving." The chapter on the family of elders deals with the hard core of patients—the senile group. The authors show the effect of ward mothers upon the sizable numbers of hospital population who

work in the hospital, and show how the security achieved often makes the difference between continued hospitalization and discharge.

Again and again the authors emphasize the need for a "conscious recognition of the steps in remotivation, all the way from marked regression to discharge," as incorporated into the total effort and program. Aides must be made part of the treatment team. Staff must participate in the patient society. Within the patient group, the sick can help the sicker. Every attempt should be made to introduce activities in the ward—activities that are as normal as possible and oriented toward future life outside. Encouraging programs can be developed in spite of many real difficulties.

A profound respect for the individual, for individual treatment and goals is a constant theme in the book, and a worthy reminder to all who have to deal with large numbers of the mentally sick. This book should be read by all disciplines working with the emotionally disturbed. The authors and the Russell Sage Foundation sponsoring this study are to be congratulated for a meaningful contribution and a heartening message to all workers in the field of mental health.—JOSEPH D. TEICHER, M.D., Child Guidance Clinic of Los Angeles.

### PSYCHOPHYSIOLOGIC MEDICINE

By Eugene Ziskind, M.D.

*Philadelphia, Lea & Febiger, 1954. 370 pp.*

This book actually contains two elements: a report of the operations of the training program in psychophysiologic medicine at the Cedars of Lebanon Hospital in Los Angeles, and a practical guide to the reasonably sophisticated general practitioner who wishes to learn better ways of dealing

with the emotional problems of his patients. Though the first element is implicit, it obviously has contributed greatly to the development and presentation of the second—and the reader will be impressed by both.

Achieving harmony in the collaborative efforts of "a group of psychiatrists of different orientations—psychoanalysts, psychobiologists and eclectics—in a unified program" is a worthy undertaking in itself (It would be interesting to know more about the horizontal communication problems and their solution.) In such a situation, many authors would weary and confuse the reader by cross-references and explanations designed to place the various "schools" in proper relationship one to the other. The author has courageously and lucidly concentrated on "what is common to most psychiatric thinking," leaving the differences and deviations to a special section of the book.

With this excellent philosophy Dr. Ziskind has produced a practical, down-to-earth book which steers a beautifully sane course between the patronizing attitude displayed by many "courses for the general practitioner" and the oversimplified, offhand manner of do-it-yourself treatises on psychotherapy. Nowhere is there any attempt to gloss over the difficulties; instead, the author offers directions and examples where these are appropriate and suggests intuitive or commonsense approaches where specific guidance is not indicated or possible. It is difficult to imagine a physician (or a medical student) who would not find the book interesting and useful.

Perhaps the outstanding characteristic of the work is the fact that it constantly emphasizes the basic position of the physician, relating all matters of technique (history-taking, therapy, etc.) to his customary activities rather than implying that he should



learn a brand-new orientation. In a few areas there may be disagreement; for example, this reviewer is inclined to feel that judicious medication can be used more frequently to support both the usual role of the physician and the psychotherapy which may be his main tool. Also, some physicians are sure to be disappointed that there is not some factual discussion of the problem of charging patients for the longer periods of time required for psychotherapy.

The last section in the book, which deals with the schools of psychiatric thought, probably will have less practical significance to the practicing physician but should diminish a great deal of the undignified confusion resulting from the doctrinaire and cultist pronouncements which—unfortunately—make up much of present-day psychiatric literature. For medical students, this wise and tolerant presentation should be required reading.

One can confidently predict an enthusiastic reception for this badly needed and well-written volume. Its very practicality forces one slight criticism: The subject index is poorly arranged and the subjects seem rather distantly related to the material listed under them. Improvement of this area in the editions which will be sure to follow will make the book even more useful than it is in its present form.—C. H. HARDIN BRANCH, M.D., University of Utah Department of Psychiatry.

## MENTAL DEFICIENCY

By L. T. Hilliard and  
Brian H. Kirman

*Boston, Little, Brown & Company, 1957. 517 pp.*

This book is the product of two British psychiatrists who have specialized in the

field of mental deficiency. They have collaborated with a team of two psychologists, an occupational therapist and a neuropathologist to produce a volume which is outstanding for its stress on the social and clinical aspects of this field of psychiatry.

The text is divided into three main sections. The first deals with the general problem of mental deficiency, including its legal, social, etiological and psychological phases. The second section is devoted to problems of the mentally handicapped individual in various phases of his development and includes chapters on educationally subnormal, uneducable, physically handicapped and mentally disturbed children. The third section reviews the present possibilities of treatment and training with emphasis on employment and rehabilitation.

The authors are to be commended for unusual objectivity and thoroughness in presenting a wealth of well-documented references in all sections of this work. Controversial subjects such as confusing terminology and classification, as well as conflicting theories of etiology, diagnosis and treatment are handled skillfully. Special consideration is placed on the importance of home care wherever possible for the mentally handicapped child. The necessity of a prolonged observation of the child and adequate assessment of his intellectual resources before institutionalization is stressed.

The chapter on neuropathology is well illustrated with many photographs of gross and microscopic sections of various disease entities. An abundance of well-chosen clinical case reports and photographs is generously interspersed throughout the book. These serve to maintain the authors' main theme that mental defect is a wide social problem rather than merely a separate branch of clinical medicine. As a minor

criticism, some of the newer aspects of treatment in such diseases as phenylketonuria and Wilson's disease do not receive adequate attention. It is hoped that a future volume will correct these deficiencies. The last chapter of advice to parents is especially well written and includes the statement, "It is now generally appreciated that in dealing with many problems of children it is more important to treat the parent than the child. This is particularly true of the defective child."

Although the book is oriented toward mental deficiency services available in Britain and is heavily influenced by the National Health Service Act, its clarity, completeness and objectivity make it an excellent source of information. This volume is highly recommended not only for physicians but also for social workers, psychologists, teachers and others concerned with the welfare of the mentally handicapped individual.—LEO KANNER, M.D., and ALLAN SCHWARTZBERG, M.D., Johns Hopkins Hospital.

## THE MOON IS FULL

By Aileen Adair

*New York, Philosophical Library, 1957. 200 pp.*

In this candid and frankly illuminating volume the author poses the question: How much of "lunacy" prevails in the minds and hearts of the "sane" as they go about their everyday businesses and professions in search of personal rewards and the well-being of their fellowmen?

The reviewer feels that Dr. Adair's work is too telescopic and much too comprehensive for a brief *critique*.

As for background, the author was the daughter of a medical superintendent of a

mental hospital in the British Isles. In her youthful years she was more devoted to the perusal of medical literature than to the diversions of Grimm's fairy tales.

*The Moon Is Full* deals with practical problems in the treatment of the mentally ill and the mentally deficient. Incidentally, the author displays an unusual degree of sympathy and understanding with the problems of the latter.

Her case histories are abundant and well chosen. They illustrate specific illnesses, their legal aspects, treatment efforts and the effects of institutional morale. Interpersonal relationships of staff are highlighted in terms of their effect upon patient treatment. Recruitment problems seem to be influenced by the same factors as those prevalent in the U. S.—namely, program, prestige and salary.

Since the author reveals her own conflicts, her story is one of personal as well as professional experience and struggle. Her account is recommended to all persons interested in advancing their own knowledge and in improving the standards of the care and treatment of the mentally ill and deficient.—MARYAN BRUGGER CURINA, Illinois Association for Mental Health.

## HELPING THE VISUALLY HANDICAPPED CHILD IN A REGULAR CLASS

By Anthony J. Pelone

*New York, Teachers College, Columbia University 1957. 99 pp.*

The school administrator who is faced with the problem of providing educational facilities and services for a child who is handicapped because of a severe visual defect

will find Dr. Pelone's book a worthwhile addition to his library.

In a most interesting and readable manner the author defines the degrees of visual handicaps, explores current thinking as to the most satisfactory methods of educating visually handicapped children, and explains in considerable detail the provisions of a recently amended federal act intended to promote education of the blind.

In his chapter on the partially seeing child in the regular class the author explains the ways in which the visually handicapped child differs from his peers and—even more important—points out their many similarities. The unique needs of the totally blind child attending the regular class are described in a separate chapter. The role of the itinerant teacher as an active member of the team working with the blind child is also discussed.

The three appendices, which give a fairly complete glossary of eye terms and suggested lists of equipment and materials (with commercial sources) for partially seeing and blind children attending regular classes, add to the value of this book as a ready reference for the school administrator and his staff.

This book might well be called *Understanding and Accepting the Visually Handicapped Child in the Regular Class*. It could be utilized as a handbook and guide for the coordinator of special educational services of a school system, since the author describes in a concise manner the role of each member of the school team who should be concerned with the visually handicapped child's satisfactory integration in the regular class setting. Indeed, even the parents of a blind or visually handicapped child who attends the regular class will find this well-written book informative and comforting.—JANE ANDERSON MACCALLUM, New York State Education Department.

## PIERRE THE PELICAN

New revised and extended series  
Messages 1 to 28

By Loyd W. Rowland, Ph.D.

New Orleans, Louisiana Association for Mental Health, 1957.

At a time when so much effort has been directed toward the detection or correction of mental and emotional illness it is encouraging to observe the shifting emphasis of the parent educator, the pediatrician and the psychiatrist toward what public health calls primary prevention or, more specifically, positive mental health. A foremost leader in this effort over the years has been Dr. Loyd W. Rowland, director of the Louisiana Association for Mental Health, and his highly successful *Pierre the Pelican* series of messages to the parents of first-born children.

This series of friendly, warm and helpful talks with parents has now been extended over a period of six years of the child's life. Twenty-eight pamphlets, humorously illustrated and featuring *Pierre the Pelican*, the symbol of wise counseling, is intended for distribution to parents once monthly during the child's first year, every other month during the second year, every fourth month during the third and fourth year, and every six months during the fifth and sixth year.

The basic concept featured throughout this series is what is now commonly called "anticipatory guidance." This term was first employed by Dr. Julius Levy, formerly with the New Jersey State Department of Health, who pointed out that behavior patterns of children were often quite normal or natural, even though frequently thought of or described as problems by parents and often by the medical profession. He further appreciated that the parents' attitudes toward these events in the early weeks and



months of infancy make up the environment which forms the basis of the child's developing personality. Accordingly, by being helped to anticipate situations and certain types of conduct, parents were better able to acquire desirable attitudes toward their children's behavior at various developmental periods and to use more desirable methods of dealing with them. In a sense, then, this series of messages helps parents to acquire the attitudes and understanding about their first child and themselves which they might with good fortune have acquired only after having had several children.

The use of repetition, the appeal to the experience of parents themselves, the simplified material and vocabulary, and the use of a mythical character Pierre contributes to making direct advice more palatable and acceptable. In this way, certain basic principles of child care have been emphasized. These include the importance of the parent as a teaching example, family affection and child acceptance, the process of maturation and readiness, individual differences, the enjoyment of learning, the acceptance of individual limitations, and the seeking after causes of behavior.

It is apparent that not only may parents benefit from the simple, relaxed, conversational manner used throughout the series, but that professional persons can learn to adopt a similar non-dogmatic, non-authoritarian approach in their work with children and parents. Teachers, public health nurses and physicians would be particularly urged to study the language and approach used in these pamphlets, in order to increase the effectiveness of their communication, lessen anxiety and increase their empathy.

Pierre is a very wise bird indeed for having demonstrated a practical way of preventing or lessening some of the forces that might otherwise lead to mental or emotional imbalance, and of improving the attitudes

and behavior of parents toward their children in the direction of mental health. How much we all need his advice!—GEOFFREY W. ESTY, M.D., New Jersey State Department of Health.

## THE GUILTY AND THE INNOCENT; MY 50 YEARS AT THE OLD BAILEY

By William Bixley

*New York, Philosophical Library, 1957. 176 pp.*

William Bixley is described only as a "supervisory official of Old Bailey"—his exact role being nowhere defined. Apparently he was a court attendant. Here, he reminisces about the dramatic trials held at that court. He smacks his lips over the sadistic activities of some of the defendants, but is devoid of any grasp of the meaningful implications of such behavior. He recites the strange antics of strange law-breakers in a casual anecdotal way, and assigns moralistic value judgments. For example "brutish monster guilty of murder" or "the slave of monstrous lusts"; "a strange brooding look in her eyes that betokened madness" or "they are all gutless when the inevitable punishment is administered"; "unprincipled and amoral rogue," and so on. Mr. Bixley's psychiatric naïveté is remarkable. Thus, he says that one obviously paranoid defendant would have won a little sympathy if only he had given sound evidence to justify his suspicions—apparently taking the position that psychotic people should reason sanely about their delusions.

The stories shuttle back and forth without any order, and the author often forgets to make clear the dates of the various events. The book is poorly bound, the paper pulpy and the illustrations non-illustrative. (For instance, the only picture of Old Bailey itself is dated 1841!) In all,

this slim volume provides an evening of light and passive reading for a light and passive reader.—HENRY A. DAVIDSON, M.D., Overbrook Hospital, Cedar Grove, N. J.

## PRESCRIPTION FOR SURVIVAL

By Brock Chisholm

New York, Columbia University Press, 1957. 92 pp.

Today more people than ever are aware that we all live in one world. Many people have become sophisticated in the complexities of what determines human behavior. More people than ever before are also acquainted with the changing trends in human affairs throughout our one world virtually as these trends develop, and are increasingly interested in their social and individual implications.

Dr. Chisholm, as the first director general of the World Health Organization and president of the World Federation for Mental Health, has been in a strategic position to evaluate these tremendous changes, particularly those of the last few years, in terms of the requirements they impose on human beings for adapting if they are to survive and remain reasonably healthy. This fascinating group of four essays was delivered as the Bampton Lectures at Columbia University.

Dr. Chisholm suggests that many attitudes and institutions and much human behavior up to now considered normal have to be changed. He casts an eye knowingly over one culture and another, indicating rather than categorically stating how it is this seems to be so. Then he suggests some ways by which these changes may come to pass.

This little volume is heartily recommended to all readers interested in the subject of individual and social integration for

the challenge, the warning and the fresh ideas it presents.—OSCAR E. HUBBARD, M.D., University of Mississippi School of Medicine.

## MENTAL HEALTH IN COLLEGE AND UNIVERSITY

By Dana L. Farnsworth, M.D.

Cambridge, Harvard University Press, 1957. 244 pp.

Educators everywhere are beginning to realize, in these critical times, that the chief problem confronting civilization is not the technical control of atomic energy, but the harnessing of man's energies, particularly his aggressive ones, to constructive uses. This concern appears to lie at the heart of Dr. Dana Farnsworth's informative and captivating new book. He speaks from his two decades of experience in student medicine and student psychology with considerable authority and urgency. And he speaks especially of the vital necessity for higher education to teach *by example*, as well as by precept, the value of applying the spirit of patient inquiry to everyday human relations—notably, to prejudices, misconceptions, antagonisms and misconduct of all kinds. For, although resistance remains formidable to the recognition of profound emotional elements in "normal" life, twentieth-century medical psychology has amply confirmed what Freud first pointed out in *The Interpretation of Dreams* and in *The Psychopathology of Everyday Life*—that powerful emotional undercurrents influence human behavior in health as well as in disease.

Dr. Farnsworth does not propose that teachers become psychiatrists or psychoanalysts, nor that the latter become teachers. But what he believes is that educational progress in particular and human welfare in general depend on achieving a juster and

better control over these submerged emotional elements, and that this can be better done by bringing them out into the light of day than by driving them underground, only to have them recur with renewed force.

It would be misleading to give the impression that Dr. Farnsworth's book is primarily concerned with these theoretical matters. On the contrary, it is especially valuable to the educator because of its eminently practical approach to student life and the learning process. It contains a wealth of material on the very real educational problems of today, often presented in historical perspective, as in the interesting chapter on student customs, morale and attitude. The chapter on counseling and psychotherapy gives an illuminating discussion of what there is in common between these two approaches and how they differ. The chapters on the administration and the psychiatrist and on emotions and the curriculum accent and illustrate how fundamentally alike are the aims of the educator and the psychiatrist, and how each can contribute more to the education of students by supplementing and enriching his own viewpoint with that of the other.

Psychiatry during the last few decades has given fresh support for an old idea about experience being the best teacher—namely, that optimal learning is closely connected with the interests and vital problems of actual daily life, and that these

in turn cannot be forced or arbitrarily imposed. As Earnest pointed out in *Academic Procession* (New York, Bobbs-Merrill Co., 1953), universities prior to the present century were largely given to forcing students to learn by rote material that seemed to them far removed from contemporary life. Today the coercive, inflexible and impersonal attitudes in the teachers of the past are seriously suspected of blocking rather than facilitating the learning process. Dr. Farnsworth remarks that they only seem to "perpetuate rebellion, negativism and hostility" on the part of students. Instead of complaining about the "immaturity" of students, or of relying on punishment alone to cure it, Dr. Farnsworth reminds us that: "Immaturity in all its forms—lack of knowledge, misconceptions, prejudice, sensitivity, tensions between individuals and groups, and unreasonable fears—is the reason for the existence of the teacher as a professional person." And it is also the reason for the psychiatrist's profession. He therefore proposes that teachers and student psychiatrists co-operate in bringing an attitude of personal interest and understanding to student viewpoints and difficulties as they present themselves—without, however, any sacrifice of the ideal that students and university should share together: namely, the search for excellence and for optimal achievement.—LOUIS E. REIK, M.D., Princeton University Department of Health.



# Notes and Comments

## NUMBER OF PATIENTS STILL GOING DOWN

A continuing decline is shown this year in the rolls of U. S. mental hospitals.

The decrease, progressive since 1956, indicates a definite favorable trend in treatment of mental illness. Prior to 1956, mental hospital rolls had increased steadily for 25 years.

Resident populations in state and county mental hospitals of 18 representative states decreased by 3,611 between June 1957 and June 1958. Projecting these figures to the entire United States gives an estimated total reduction of over 7,000, or about 1%. The reduction was somewhat less than that noted during the first year after the turning point in 1956 and slightly above that shown last year.

Hospital admissions, rising during the past three years, have been offset by even greater increases in hospital discharges, resulting in a net drop in hospital population. In 1955, 119,000 patients were discharged from public mental hospitals and in 1956 and 1957 comparable figures rose to 133,000 and 145,000.

The sharp increase in discharge of mental patients has created a new and acute problem, Judge Luther Alverson, president of the National Association for Mental Health, said recently. "Many recovered patients are returning to communities unprepared to receive them. There is still a great deal of unwarranted fear and hostility toward the returned patients, even among neighbors and family members. Employers, while expressing sympathetic interest, still resist hiring former patients. Facilities for out-patient follow-up medical care are practically non-existent.

"Many patients are unable to contend with these obstacles and break down and have to return to the hospital. Others are

forced into an unsatisfactory adjustment and become a burden to themselves, their families and their communities."

To meet this new problem, Judge Alverson said, NAMH is pressing for local programs of social, vocational and psychiatric rehabilitation and affiliates of the organization have given a #1 priority to these programs.

## CARE AND TREATMENT

Emergency treatment around the clock for private and semi-private psychiatric patients is a feature of New York City's Gracie Square Hospital.

The 6-story air-conditioned structure, built at a cost of \$3,500,000, has a capacity of 232 beds. All recognized forms of treatment will be available. The hospital will maintain a day and night program for out-patients and a geriatric service for the aged. It will also accept patients addicted to opiates, barbiturates and alcohol.

The hospital's location—in crowded Manhattan—is in line with the current philosophy that the mentally ill should be treated in the heart of the community where relatives and referring doctors can easily visit.

\* \* \*

The U. S. Internal Revenue Service has ruled that tax-deductible medical care includes the entire cost of institutional care for a person who is mentally ill and unsafe when left alone.

The test case involved a mentally retarded child whose doctor felt it was neither safe nor practical for him to remain with his parents or in an urban community. He was placed in a home with an opportunity of marginal adjustment.

\* \* \*

A survey conducted by the Pima County, Ariz., Association for Mental Health shows

that more than 1,200 Tucson school-age children are in urgent need of special service because of social or emotional problems interfering with their progress in school.

\* \* \*

Rhode Island has 1,678 children from 5 to 18 who are emotionally ill, according to a survey co-sponsored by the state mental health association. Top-priority goal of the association and other interested organizations is to fill the gap in child guidance clinic services. A goal of 8 out-patient clinic teams has been set. As in many other states, there is also great need for a residential psychiatric treatment center, especially for adolescents.

\* \* \*

Another state hospital administrator has gone abroad to study England's famed open mental hospitals. He is Dr. Arthur L. Seale, superintendent of the Central Louisiana State Hospital at Pineville.

His investigation and study is being subsidized jointly by the Louisiana Association for Mental Health and the State Department of Hospitals.

He is visiting, among others, the Horton Road and Coney Hill hospitals in Gloucester. The unlocking of these particular institutions was described in fascinating detail in the January 1958 issue of *Mental Hygiene*.

\* \* \*

Governor Averell Harriman drove the first pile October 17 for New York's first new mental hospital in 27 years.

Stressing in his speech the significance of environment in the treatment of mental patients, Governor Harriman said: "The doors of the beautiful new buildings to be constructed here will not clang shut like prison gates on the sick people who enter them for treatment. With increasing enlightenment, with the barriers crumbling between hospital and community, New York

State has emerged from the ancient shackles of superstitious fear which turned our mental hospitals into grim fortresses. We know now that environment is an essential part of treatment."

\* \* \*

New York is not spending enough on mental health research, training and community psychiatric services, in the opinion of a committee of the State Society for Mental Health. The current \$1-per-capita rate of state aid for psychiatric services in general hospitals is both "inadequate and unrealistic," according to the State Citizens Advisory Group for Mental Hospitals and Schools.

In a report presented October 27 in Albany at the society's 2nd annual mental hospital institute, the advisory group recommended the creation of standing committees on mental hygiene in both houses of the state legislature, the development of small independent units within New York's huge public mental hospitals, and closer co-operation between the hospitals and local mental health boards.

The group also reported that:

- Education and training of personnel in mental institutions have been "woefully neglected."
- Institutional environments should be more cheerful and home-like.
- Operation of large farms by mental hospitals is "debatable and probably unsound."
- Further study should be given to the possibility of restoring mental patients' full legal rights rather than treating them as incompetent before the law.

\* \* \*

On every hand these days is telling evidence that mental patients are breaking through the barriers that long isolated them from the rest of the community.

For example, five years ago not one general hospital in Kansas would take mental patients. Now 68 of the state's 167 licensed hospitals will accept them, for temporary care at least.

#### RESEARCH

Grants totaling \$124,200 for 26 continuing research projects on schizophrenia, stipends for the training of student researchers and operating costs have been announced.

The grants were made November 8-9 at a meeting of the schizophrenia research committee of the Supreme Council, 33rd Degree, Scottish Rite Freemasonry, Northern Masonic Jurisdiction. The research program is directed through the National Association for Mental Health, which was represented at the meeting by Dr. William Malamud, research director, and Dr. George S. Stevenson, national and international consultant.

With these grants for the 1959 research projects, a total of over \$1,460,000 has been contributed by the Scottish Rite for its major benevolence—research in the causes and treatment of schizophrenia. Sovereign Grand Commander George E. Bushnell of Detroit said funds contributed by Freemasons throughout the northern Masonic jurisdiction during December would go for the support of schizophrenia research.

The following grants were renewed:

Dr. Kenneth Appel, Institute of the Pennsylvania Hospital, Philadelphia. Effects of drugs on specific personality functions. \$5,000.

Dr. Philip Bard, Johns Hopkins University, Baltimore. Brain mechanisms involving aggressive behavior. \$2,000.

Dr. George H. Bishop, Washington University, St. Louis. Cortical activity in mammals. \$2,500.

Dr. Samuel Bogoch, Massachusetts Men-

tal Health Center, Boston. Studies of neu-raminic acid in schizophrenia. \$4,800.

Dr. C. H. Hardin Branch, University of Utah, Salt Lake City. Indole studies in schizophrenia. \$5,000.

Dr. Norman Q. Brill, University of California, Los Angeles. Assay of ACTH in the blood in relationship to schizophrenia. \$5,500.

Dr. P. H. Bulle, Georgetown University, Washington, D. C. Determination of the presence and effects of serotonin and related substances in the cerebrospinal fluid. \$5,000.

Prof. Erwin Chargaff, Columbia University College of Physicians and Surgeons, New York City. The chemistry of some metabolic processes of the brain. \$2,000.

Dr. Robert Allen Cleghorn, McGill University, Montreal. Neurohumoral and endocrine functions in schizophrenia. \$4,500.

Dr. Daniel H. Funkenstein, Boston Psychopathic Hospital. Psychological and biochemical studies of reactions to stress. \$4,000.

Dr. Francis J. Gerty and Dr. Leo Abood, University of Illinois Neuropsychiatric Institute, Chicago. The chemistry and effects of drugs that produce symptoms of mental diseases. \$3,500.

Dr. J. S. Gottlieb and Dr. Charles E. Frohman, Wayne University, Detroit. Studies of phosphorus metabolism in schizophrenics. \$5,000.

Dr. Hudson Hoagland, Worcester Foundation for Experimental Biology, Shrewsbury, Mass. Effects of some blood constituents of schizophrenics on animal behavior. \$5,000.

Dr. Franz J. Kallmann, New York State Psychiatric Institute, New York City. Genetic studies of preadolescent forms of schizophrenia. \$4,000.

Dr. Irving Kaufman, Judge Baker Guidance Center, Boston. Studies of the treat-



ment process of childhood schizophrenia. \$4,800.

Dr. Peter Knapp, Boston University School of Medicine. Methodological studies of affective reactions. \$4,000.

Miss Meta A. Neumann, St. Elizabeths Hospital, Washington, D. C. Histochemical studies of the basal ganglia. \$5,000.

Dr. Zygmunt A. Piotrowski, New Jersey Neuropsychiatric Institute, Princeton. Preceptanalytic studies of schizophrenia. \$3,000.

Dr. Marian Putnam and Dr. Beata Rank, James Jackson Putnam Children's Center, Roxbury, Mass. Analysis of treatment process of children manifesting "atypical" behavior. \$4,500.

Dr. Ralph D. Rabinovitch, Hawthorn Center, Northville, Mich. Indole studies in schizophrenic children. \$4,000.

Dr. Carl Schmidt, University of Pennsylvania School of Medicine, Philadelphia. Effects of drugs on the nervous system. \$3,000.

Dr. Harry Sobotka, Mount Sinai Hospital, New York City. Microbiologic assay of drugs used in mental illness. \$4,600.

Dr. Ian Stevenson, University of Virginia School of Medicine, Charlottesville. Clinical and physiological studies of the effects of drugs. \$6,000.

Dr. Heinrich Waelsch, New York State Psychiatric Institute, New York City. New aspects of amine metabolism. \$3,000.

Dr. Alfred Washburn and Dr. John Benjamin, Child Research Council, University of Colorado, Denver. Analytic studies of personality development. \$5,000.

Dr. John C. Whitehorn, Johns Hopkins University, Baltimore. Studies of the process and predictability of results of treatment of schizophrenics. \$5,000.

• • •

Researchers and clinicians from all parts of the country met in Washington October

27 to lay the groundwork for new research on the effects of tranquilizers and other drugs on children. The conference was called by the Psychopharmacology Service Center of the National Institute of Mental Health.

Clinical and laboratory psychologists, pediatricians, psychiatrists, social workers and neuropharmacologists combined their knowledge and experience to pinpoint the most crucial problems in the use of these drugs on children. They also recommended ways that the problems can best be attacked through research on normal children as well as on the emotionally disturbed or mentally ill or retarded.

The group discussed how drug effects can be accurately measured, how to determine whether drugs can safely be given to children for long periods of time, and the effect of drugs on learning ability and other aspects of a child's development.

\* \* \*

A research center for the study of drugs and their use in the treatment of mental illness was officially opened November 20 at Saint Elizabeths Hospital in Washington, D. C. The project is operated jointly by the hospital and the National Institute of Mental Health.

The new Clinical Neuropharmacology Research Center is being equipped for a comprehensive, scientific assessment of the tranquilizing and energizing drugs and their effects on mental function, particularly in the treatment of mental disorder.

Dr. Joel J. Elkes, NIMH pharmacologist and former chairman of the department of experimental psychiatry at the University of Birmingham in England, is director of the center.

Dr. Robert H. Felix, NIMH director, said there has long been a need for a research center in a mental hospital to work

in conjunction with the clinical center in Bethesda, Md. He noted that Saint Elizabeths, one of the country's outstanding mental hospitals with a patient-population of 7,500 and located only a few miles from the clinical center, is ideal for such a collaborative program.

Dr. Winfred Overholser, superintendent of Saint Elizabeths, said the hospital has always welcomed promising innovations. "This program, I believe, holds particular promise not only for Saint Elizabeths but for psychiatry in general," Dr. Overholser commented. "I am confident that this carefully planned research undertaking will bring forth knowledge that will guide us in the use of drugs and from which new effective treatment methods will evolve," he said.

The building selected for the project houses 350 patients and provides opportunity for intensive clinical studies. Laboratories and other facilities for basic research are being installed.

Working together on the project will be psychiatrists, psychologists, pharmacologists, biochemists, physiologists and a variety of other research specialists. They are starting an extensive series of studies for determining exactly what happens, physically and psychologically, when drugs are used in the treatment of mental disorder in a hospital. This will include clinical studies with patients suffering from different types of mental illness and also basic research on the actions and reactions of the various drugs.

The program will also include studies designed to measure the changes in hospital management and care brought about by the use of the drugs and how such environmental changes affect the patient. The very fact that the drugs bring withdrawn patients out of their defensive retreat so that they can be reached by psychotherapy also makes

them more responsive to other influences in their environment, Dr. Elkes pointed out.

"The attitudes of hospital personnel, the physical arrangements for the patient's care, even the lay-out of the ward itself, enter into the therapeutic process and become more meaningful for good or ill," he said.

\* \* \*

A 2-year study of mental depression has been undertaken by Rutgers University and the New Jersey Department of Institutions and Agencies. The National Institute of Mental Health is subsidizing the investigation with a grant of \$158,000.

The principal aim is to measure the effectiveness of two treatment methods for depressed mental patients. The methods are electro-convulsive therapy (shock treatment) and the use of iproniazid, an anti-depressant drug.

The causes of depressions will also be investigated.

Dr. V. Terrell Davis, state director of mental health and hospitals, said the study "represents the beginning of major collaborative research between the state university and the state hospital system." It will call on the professional skills of psychiatrists, psychologists, psychiatric social workers and nurses, biochemists and physiologists.

\* \* \*

A 5-year study of the social and psychological stresses that arise when homes are razed and families relocated to make way for industrial expansion is getting under way in Boston's West End. It will be carried on by the Center for Community Studies with Dr. Erich Lindemann, Harvard University professor of psychiatry, as the principal investigator. It will be subsidized by the National Institute of Mental Health.

The research will include interviews with both husbands and wives in a random sample of 400 families. The study team will also interview small groups of selected people on special problems: family life, community life, adaptation to crises, and the meaning of the physical environment. Those interviewed will be questioned before moving and again several years later.

\* \* \*

Significantly more mentally defective children are born during the winter than at any other time of year, a recent study shows.

A significant number of the mentally defective children born between 1913 and 1948 and now cared for at a state school in Columbus, Ohio, were born in January, February or March, two researchers—Dr. Hilda Knobloch and Dr. Benjamin Pasamannick—have found. They conclude from this that mental defect is related in some way to the season of conception.

Writing in the September 1958 issue of the *American Journal of Public Health*, they point out that damage occurring during the third month after conception (when the cerebral cortex of the unborn child is becoming organized) could affect intellectual functioning.

"The months when this might happen would be June, July and August, the hot summer months when pregnant women might decrease their food intake, particularly protein, to dangerously low levels and consequently damage their developing babies," the authors note. "If this were so, one would expect that hotter summers would result in significantly more mental defectives born than following cooler summers.

"This was exactly what was found to a highly significant degree."

The authors conclude that inadequate dietary intake during pregnancy because of

heat or substandard economic conditions may be "an important link in the vicious cycle that results in poor physical and mental growth."

A similar article on season variation in the incidence of severely crippling mental disorders appeared in the October issue of the *American Journal of Psychiatry*. It was written by Dr. Nelson J. Bradley and Rubel J. Lucero.

They found that mental patients between 60 and 69 entered the hospital most frequently in November and least frequently in April. No other age group varied from month to month.

Psychoneurotics, they found, entered the hospital most frequently in June, July and October, least frequently in December, January and February. Those who were married varied the most.

The authors based their observations on a 3-year study of 976 consecutive admissions to the Willmar State Hospital in Minnesota, and emphasize that their findings apply only to patients in rural areas.

\* \* \*

The Hofheimer Prize of \$1,500 is awarded annually by the American Psychiatric Association for an outstanding research contribution in the field of psychiatry or mental hygiene which has been published within a 3-year period up to the date of the award. Studies in press or in preparation are not eligible.

This competition is open to citizens of the United States and Canada who are 40 years of age or under at the time the study was submitted for publication or to a research group whose median age does not exceed 40.

The next award will be made at the annual meeting of the APA in April 1959. Entries submitted to the prize board before February 15, 1959 will be considered. Eight



reprints or duplicated copies of each entry as well as the necessary data concerning age and citizenship should be sent to Dr. John I. Nurnberger, chairman, Hofheimer Prize Board, 1100 West Michigan St., Indianapolis 7, Ind. All entries are independently evaluated by each member of the Hofheimer Prize committee and final selection is determined by equal vote.

### TRAINING

The training of mental health specialists has improved both in quantity and quality during the last decade, in the opinion of the National Institute of Mental Health.

In a comprehensive report to Congress on the institute's training program at the end of its first 10 years, NIMH lists 10 methods used to expand the nation's mental health resources:

- Pilot projects to develop ways of training specialists for work in key mental health problem areas.
- Grants to enable promising psychiatrists and scientists to devote themselves to careers in mental health research.
- Grants to enable qualified individuals to make a career of mental health teaching.
- Psychiatric teaching for undergraduate nursing students.
- Training of specialists for community mental health activities.
- Senior stipends for advanced mental health training of established teachers, researchers and administrators.
- Part-time stipends for medical students wanting experience in psychiatric clinics and research laboratories.
- Training programs in mental health research for personnel in the basic and applied sciences.

- Training programs for epidemiologists and biometricians for medical research, post-sophomore research fellowships for medical students and postdoctoral fellowships for outstanding foreign scientists.

- Grants to train social workers and psychologists for vitally needed mental health work in the schools.

In the decade between July 1, 1948 and June 30, 1957 NIMH spent \$33,650,156 on its mental health training programs.

This year NIMH expects to launch a new series of grants designed to increase the supply of research psychologists.

Looking ahead, the report forecasts a heavy emphasis for the next five years on the establishment of basic science departments of human behavior in medical schools. Also needed, NIMH says, is improved research training for university students early in their professional or pre-professional education. Another step, Congress was told, is the training of personnel for preventive mental health services and for treatment and research work in geriatrics, alcoholism, juvenile delinquency and mental retardation.

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Dr. Cyril J. Ruilmann, Texas' recently appointed director of mental health and hospitals, has been elected chairman of the Southern Regional Council on Mental Health Training and Research for 1958-59. The council, composed of representatives of the governors of 16 southern states and other specialists in mental health professions, serves as an advisory body to the Southern Regional Education Board.

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In a direct attack on some of the training and research problems in the field of mental retardation, the Southern Regional Educa-

tion Board has formed a panel to advise and assist the board in:

- Assessing the research and the professional and technical training needs in this field.
- Identifying promising practices in meeting these needs.
- Formulating various solutions to problems blocking the meeting of needs.
- Stimulating the implementation of recommended solutions.

The board is also sponsoring a series of conferences that bring together five or six research workers engaged in similar studies to discuss their common interests and problems. One 2-day conference focused on the problem of measuring and analyzing abnormal activity in mentally retarded and disturbed children. Another centered on studies of the brain stem in relation to learned and unlearned behavior. The next scheduled conferences will be on biochemical research with mongoloid children and on experimental studies of the learning process in retardates.

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Meeting in special session November 6-7 in New York, the board of the National League for Nursing approved measures to improve the education of psychiatric aides. The organization will stimulate experimental pre-service education programs for aides, help set up educational standards, and prepare curriculum materials.

The board also reaffirmed an earlier statement that "psychiatric aides who give care to the mentally ill are practitioners of nursing," approved an earlier recommendation that NLN assume leadership and responsibility in the training of aides as well as other nursing personnel caring for psychiatric patients, and reiterated its intention of

fostering and improving on-the-job education of aides.

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A total of 33 grants for in-service training of workers in mental institutions of southern states have been awarded to date by the Southern Regional Education Board under its program in mental health training and research. Five more applications are being processed.

Nineteen mental hospital employees and 14 employees in training schools have received an average of \$202 to visit facilities for the care and treatment of the mentally ill or retarded in 10 different states.

More than half of the grants have gone to personnel in Virginia and Louisiana. The remaining grants were awarded in Kentucky, South Carolina, North Carolina, Maryland, West Virginia, Oklahoma and Texas.

These in-service training grants were made possible by a \$90,000 grant by the National Institute of Mental Health. They are designed to enable staff members of mental hospitals or training schools in the South to observe new or unusual programs in other hospitals anywhere in the country.

Visits averaging 9 days were made to a variety of institutions including the geriatrics unit and research unit of a mental hospital, an open door hospital and a facility for emotionally disturbed children. Grantees observed programs ranging from food service management to teaching music to retarded children.

All but six of the visits were made to states outside the South. Seven grant recipients went to Connecticut, 10 to New York, 3 to Michigan and Ohio, 2 to Illinois, Florida and Washington, D. C., and one to Virginia, California, Maryland, Massachusetts and Kansas.

Reaction of the grantees has been very favorable, the SREB reports. Grants have

been awarded teachers, hospital superintendents, psychiatric social workers, attendants, nurses, librarians, psychologists, physicians and directors of research, volunteer programs, recreation, education and food service.

The 2-year grant from NIMH permits the SREB to award approximately 100 grants each year. Grants up to \$500 to cover travel and maintenance are made for 1- and 4-week visits. Applications are still being accepted by SREB. Those interested should write directly to the Southern Regional Education Board, 881 Peachtree St., N.E., Atlanta 9.

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A new performance test for psychiatric aides is being distributed by the National League for Nursing.

It includes a test in elementary psychiatric nursing and a second one in basic nursing procedures and elementary nutrition. Norms for the tests are based on the performance of more than 4,000 psychiatric aides and attendants who had been employed in 63 mental hospitals for at least a year. This test service is available to hospitals which employ psychiatric aides and attendants, and mark NLN's first venture in the construction of a test for employed personnel.

Cost of the test service is 75¢ a person tested with the elementary psychiatric nursing test, and \$1 a person tested with the basic nursing procedures and elementary nutrition test. The latter provides a score in each of the two areas tested, plus a total score.

Further information about the test may be obtained from the National League for Nursing, 2 Park Ave., New York 16.

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Through a grant from the Public Health Service, a number of National Institute

of Mental Health traineeships have been made available to men and women interested in advanced study in the doctoral program in social work and social science offered at the University of Michigan. Applicants for the program may be considered also for fellowships provided under a grant from the Russell Sage Foundation. Fellowship stipends range from \$600 to \$3,600, including dependency allowances.

The interdepartmental program offers degrees combining social work with either sociology, social psychology, psychology or economics, and prepares students for careers in research, teaching and policy development. Students with bachelor's degrees only, as well as those with a master's degree in social work or a social science discipline, may apply for admission to the interdepartmental program.

Fellowship applications will be received up to February 1, 1959. Applications for admission may be filed up to June 1, 1959. For detailed information and application forms, write to Dr. Henry Meyer, School of Social Work, University of Michigan.

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Medical schools are being encouraged to apply to the National Institute of Mental Health for grants with which to finance psychiatric training of family doctors. Of \$1,300,000 appropriated by the 85th Congress for this purpose, \$800,000 is available to the schools as stipends for physicians who have been practicing at least four years and who wish to take standard psychiatric residency training.

The other \$500,000 will be available to the medical schools (and to psychiatric departments of hospitals and psychiatric societies) to pay instructors of postgraduate courses in psychiatry for general practitioners.

Dr. Charles E. Goshen, director of the



American Psychiatric Association's general practitioner education project, is prepared to aid in formulating, evaluating and publicizing training programs, obtaining psychiatric lecturers, establishing liaison with other medical groups, and applying for grants.

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A marked increase in grants for the training of more mental health personnel was reported this fall by Dr. Robert H. Felix, director of the National Institute of Mental Health.

Grants to date in this fiscal year total more than \$16,000,000, compared to about \$13,000,000 last year. They are financing the training of new psychiatrists, psychologists, psychiatric social workers, psychiatric and public health nurses.

## PUBLIC INFORMATION

Increased public awareness of mental illness as New Jersey's leading health problem is noted in the latest annual report of the state mental health association.

Dr. Edward P. Duffy, Jr., president, said this growing concern had been observed by his association and its 14 county chapters in six different advances:

- The rapid growth of mental health clinics and child guidance centers. Under New Jersey's Community Mental Health Services Act of June 1957, which the mental health associations vigorously supported, 19 of the state's 21 counties have taken first steps toward the organization of clinics. This past year mental health volunteers directly helped to launch three clinics in Gloucester, Morris and Middlesex counties.

- Increased requests for information and help in finding care and treatment for emotionally or mentally ill residents.

- Increased requests for publications, exhibits, films, plays and speakers on mental health.

- Increased attendance at special seminars on mental health for teachers, clergymen, police officers, nurses and industrial leaders.

- Significant legislative gains, including larger appropriations for the care of hospitalized mental patients and the creation of a state mental health research program.

- A 33% increase in public contributions to the 1957 Mental Health Campaign.

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A former mental patient's fight against the fears and prejudices of his fellow workers is dramatized in poignant detail in a new Mental Health Film Board release called "Bitter Welcome."

It shows, with humor and suspense, how he battles to keep his job, his home and his self-confidence in the face of deep suspicion and outright antagonism. So far as is known this is the first film depicting the rehabilitation problems of the recovered mental patient.

Praising the film as an educational tool, the education committee of the National Association for Mental Health has recommended that all mental health associations incorporate "Bitter Welcome" in their public and professional education programs. Showings should be arranged, the committee believes, not only for the general public but for specialized groups such as doctors, nurses and the relatives of those hospitalized because of mental illness.

Prints of the 36-minute film are available (\$145 purchase, \$8.50 rental) from the NAMH Film Library, 267 W. 25th St., New York 1.

Employment of rehabilitated former mental patients is the theme of a billboard design contest to be conducted next year among New Jersey's high school students. The contest will be conducted by the Governor's Committee to Employ the Handicapped. The New Jersey Association for Mental Health has contributed \$300 toward prizes.

#### APPOINTMENT

Dr. Harvey J. Tompkins, 1st vice-president of the National Association for Mental Health and chairman of its professional advisory committee, has been named chairman of New York City's Community Mental Health Board. He will serve in the unsalaried post until December 31, 1961.

Dr. Tompkins, who is director of the psychiatric division of St. Vincent's Hospital, New York City, is also clinical professor of psychiatry at New York Hospital, a member of various local, state and national mental health committees and coordinator of psychiatric activities for Catholic charities of the Archdiocese of New York.

#### MEETINGS

Climaxing its 50th anniversary celebration, the Connecticut Association for Mental Health sponsored a state-wide institute on the returning mental patient. It was held November 7 in Hartford with Miss Mary Switzer, director of the U. S. Office of Vocational Rehabilitation, as the main speaker.

In three sociodramas psychiatrists in training at Yale University School of Medicine demonstrated various problems faced by the former mental patient. Representatives of the clergy, industry, labor, nursing, social service and the Veterans Administration discussed the community's ways of helping the patient handle his troubles.

Such topics as the employment, after-

care and social readjustment of discharged patients were also gone into in workshops.

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For the first time in history, so far as is known, the men who direct state mental health and mental hospital programs sat down together this fall to talk over their common administrative and fiscal problems. They liked the experience so much they decided to organize as a permanent group and meet regularly as the Council of Mental Health Commissioners.

Many reported better patient-staff ratios in mental hospitals, decreasing hospital populations despite the highest admission rates in history, and the greatest number of discharges ever recorded.

Twenty-nine states were represented at the meeting, held in Kansas City under the auspices of the American Psychiatric Association. An executive committee formed to work out the details of organization includes Dr. George Jackson of Topeka; Dr. Clifton Perkins, Baltimore; Dr. Harold McPheeters, Louisville; Dr. Hayden Donahue, Oklahoma City; Dr. Granville Jones, Little Rock; Dr. Addison Duval, Jefferson City, Mo.; Dr. Cyril Ruilmann, Austin, Texas; Dr. John Davis, Harrisburg, Pa.; Dr. Earl Holt, Concord, N. H., and Dr. John B. K. Smith, Juneau, Alaska.

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The American Psychiatric Association dedicated its new headquarters building at 1700 18th St., N.W., in Washington this fall.

Secretary of Health, Education and Welfare Arthur S. Flemming gave the dedicatory address October 31 in ceremonies attended by 200 APA leaders and officials from other professional organizations.

APA's top officers include Dr. Francis J. Gerty of Chicago, president, and Dr. William Malamud, New York City, president.

elect. Other officers include Dr. William B. Terhune, New Canaan, Conn., Dr. David C. Wilson, Charlottesville; Dr. C. H. Hardin Branch, Salt Lake City, and Dr. Robert H. Felix, Bethesda, Md.

APA, oldest national medical association in the U. S., was founded in 1844 by 13 physicians as the Association of Medical Superintendents of American Institutions for the Insane. In 1892 the name was changed to the American Medico-Psychological Association and in 1921 to the present title.

Over the years the membership has grown from the original 13 to 10,000. The shortage of psychiatrists in this country is still acute, however, and it is roughly estimated that at least double the present number are needed to take care of the nation's mentally ill.

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A national committee on mental health has been created within the National Association of County Officials for the purpose of working with mental health associations throughout the country.

A formal resolution calling for cooperation with the National Association for Mental Health and its affiliates was passed by county government leaders at their annual conference August 10-13 in Portland, Ore. It authorizes the formation of a national committee to "cooperate state-wide and nation-wide with accredited mental health associations in preventive programs relative to the difficult but essential task of providing more care, protection and aid for the mentally ill."

The resolution was presented to the NACO convention by Commissioner John Poda of Summit County, Ohio.

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There has been a boom in the mental

health movement, and it shows no signs of letting up.

This was a primary point of agreement among 53 leading educators and other professional workers who participated in a National Assembly on Mental Health Education held September 10-13 at Cornell University. They gathered to analyze current views on mental health education, chart its future course, and point to topics requiring research.

The assembly, initiated by Pennsylvania Mental Health, Inc., was co-sponsored by the National Association for Mental Health and the American Psychiatric Association. It was subsidized by a grant from NAMH.

"We are not suffering from lack of mental health education," Dr. Erich Lindemann pointed out in the only formal paper of the conference.

"Mental health is the topic of the day in most journals, on radio and television. Legislatures and Congress find it necessary to give increasing amounts of money to research, service and training in psychiatry, psychology and social work, and are now including demonstrations in such training for general practitioners, clergymen and law enforcement people."

Dr. Lindemann is professor of psychiatry at Harvard Medical School and psychiatrist-in-chief at Massachusetts General Hospital.

In the two and a half days of discussions that followed his talk, most conference participants conceded the need for this upsurge of activity on behalf of those who are mentally ill or might become so.

They agreed also that all professional workers—doctors, clergymen, lawyers, judges, teachers and others—are involved in mental health education. Each draws from the common well of available knowledge about what constitutes mental health, and each adapts this scientific information, in the



light of his own professional orientation, for the particular group he serves.

Members of the assembly spent a great deal of time on the matter of promoting positive mental health. All recognized the lack of unanimity about the content of the field, the uncertainty about educational techniques and their effectiveness. And despite these doubts, all recognized a strong desire among professional workers and public for more and better mental health education geared to helping people live more satisfying lives.

As viewed through the eyes of three NAMH staff members who participated—Dr. George S. Stevenson, Edward Linzer and Harry Milt—the conference at Ithaca erected a number of important signposts for mental health associations. For example, in considering the goals of mental health education one discussant pointed out that mental illness is a reality that must be dealt with. Another added that any soundly conceived program aimed at improving the lot of the mental patient and his family is bound to be effective in promoting sound principles of mental health. Conversely, educational programs designed to advance mental health should simultaneously lead toward improved care and treatment of the mentally ill.

In the view of another, mental health education had these four goals:

- The reduction of stigma and accompanying fear in our approach to all the problems connected with mental illness.
- The gathering and disseminating of accurate information on mental disorders.
- The dissemination of information on personality development.
- The stressing of steps people may use in helping themselves.

Whatever the goal of a specific program, however, many discussants felt it the mental

health association's duty to know the full range of mental health educational activities going on in the community, to examine them all in the light of the community's over-all needs, and to guide their development and expansion.

All in all, the conferees paid a good deal of attention to educational techniques.

Though some were inclined to minimize the role of the mass media in mental health education, by the end of the assembly most participants seemed ready to agree that in the last few years magazines, TV, radio and newspapers had helped to bring the subject of mental illness into the open. They noted that people seem more willing to discuss mental disorders than they used to, and are quicker to seek treatment for themselves or their relatives.

(The CBS film "Out of Darkness" was cited as an outstanding attempt to help very large numbers of people—perhaps 20,000,000—to a realization of what a psychiatrist is and what he does in psychotherapy.)

Hospital visiting was also examined as an educational technique. Some participants believed mass visiting helped to destroy the public's false stereotype of the mental patient and to create in its place a sympathetic understanding of the patient as a sick person in need of help. Others held that the best learning came not from a quick tour of the hospital but from serving there as a volunteer.

Those on the staff of a mental hospital would do well to devote time to educational activities in the community, one discussant observed. They could talk before community groups, serve as consultants to various health and welfare agencies, and participate in the professional life of the local college or university, it was said.

In addition to these well-recognized methods of education, the assembly pointed

to others, somewhat more indirect, with considerable potential: the formulation and promotion of legislation, the conducting of self-surveys, the personal involvement of thousands of volunteers.

It was generally agreed that it is pretty hard to measure the effectiveness of many of these techniques. Some take a long time to show results. Some are not reaching the right people.

Said one discussant: "The mental health movement must let its nets down deeper into the social structure to reach the depressed or submerged tenth of the population living in slums. Here are the unskilled workers, the unemployed and the migrants. The educational level is 7th grade or less.

"These people are not reached by family doctor, minister, society or union. The school teacher is the only one who constantly reaches the children on a day-to-day basis, and even her relationship is tenuous.

"A recent study indicated that twice as many people in disorganized areas had symptoms of mental illness as those in better organized areas, and they were more incapacitating. The uncertainty is how to reach them."

It was also generally agreed that wide-ranging research is a prime imperative in the mental health field. Among dozens of topics suggested for study were these:

- The content of various mental health education programs.
- The timing and appropriateness of various techniques.
- The effectiveness of educational methods in reaching the professions: doctors, lawyers, ministers and others.
- Public attitudes toward mental illness and techniques of changing them.
- The qualifications of mental health educators, lay and professional.

All sessions of the assembly were recorded and a comprehensive report of the discussions will be distributed this year. It will serve as the basis for an institute, under NAMH auspices, for key personnel of state and local mental health associations.

Those participating were Michael Amrine, science writer; Dr. Carl A. L. Binger, former president of the Mental Health Film Board; Don Belcher, of Smith, Kline & French Laboratories; Dr. Daniel Blain, Western Interstate Commission for Higher Education; Mrs. Helvi Boothe, formerly of the Menninger Foundation; Dr. Francis J. Braceland, physician-in-chief at the Institute of Living in Hartford, Conn.; Dr. Orville Brim, Jr., Russell Sage Foundation; Dr. John A. Clausen, National Institute of Mental Health; Dr. Jules V. Coleman, Dr. Ira Hiscock and Dr. A. B. Hollingshead, Yale University; Dr. Stuart W. Cook and Dr. M. Brewster Smith, New York University; Donald A. Crawford, Philadelphia management consultant; Dr. Elaine Cumming, University of Chicago; the Rev. Charles A. Curran, Loyola University; Albert Deutsch, author of *The Mentally Ill in America*; Dr. C. Douglas Darling and Dr. Dorothea Leighton, Cornell University; Dr. Henrietta Hewitt, Maryland Department of Mental Hygiene; Dr. Erik Erikson, Austen Riggs Center.

Others were Dr. Dana L. Farnsworth and Dr. Erich Lindemann, Harvard University; Charles H. Frazier, president, and Max Silverstein, executive director of Pennsylvania Mental Health, Inc.; Dr. Milton Freedman, executive director of the Mental Health Association of St. Louis; the Rev. C. Leslie Glenn, University of Michigan; Dr. John D. M. Griffin, general director of the Canadian Mental Health Association; Dr. Samuel Grob, associate director of the Massachusetts Association for Mental Health; Stockton Helffrich, National Broadcasting Company;

Miss Margaret Hickey, public affairs editor of the *Ladies' Home Journal*; Dr. John P. Horlacher, University of Pennsylvania; Rabbi Fred Hollander, Yeshiva University; Dr. Henry P. Laughlin, George Washington University; Edward Linzer, Harry Milt and Dr. George S. Stevenson, NAMH; Dr. Ralph H. Ojemann, Iowa Child Research Station; Dr. Harvey J. Tompkins, St. Vincent's Hospital, New York City; Dr. Ernest Osborne and Dr. Leo Rosten, Columbia University.

Others were Dr. Paul T. Rankin, assistant superintendent of the Detroit schools; Dr. Matthew Ross and Robert L. Robinson, APA; Dr. Howard P. Rome, Mayo Clinic; Dr. John A. Rose, Philadelphia Child Guidance Clinic; Elizabeth Ross, formerly deputy chief of the U. S. Children's Bureau; Dr. Loyd Rowland, executive director of the Louisiana Association for Mental Health; Dr. Fillmore Sanford, University of Texas; Dr. Kerry Smith, Association for Higher Education; Dr. Eliseo Vivas, Northwestern University; Dr. William Foote Whyte, New York State School of Industrial and Labor Relations, and Greer Williams, Joint Commission on Mental Illness and Health.

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The White House Conference on Aging set for January 1961 is expected to have considerable influence on medical and other programs for the nation's "senior citizens." The conference, authorized by the last Congress, is to be under the over-all direction of a national advisory committee composed of outstanding citizens and recognized leaders in gerontology, economics, education, health, housing, recreation, religion and welfare.

Funds have been provided to help the states hold state conferences on aging in advance of the Washington meeting. These state conferences, likewise, are to be preceded by community meetings involving in-

dividuals, groups and organizations concerned with aging.

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Staff members of mental hospitals, psychiatric services of general hospitals and schools for the mentally deficient, as well as mental health authorities of the U. S. and Canada, met in Kansas City October 20-23 for the 10th Mental Hospital Institute. They exchanged information on 18 topics bearing on the care, treatment and rehabilitation of mental patients.

The institute has been sponsored each year since 1949 by the American Psychiatric Association's mental hospital service.

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Recruitment of more volunteers, particularly men and women with backgrounds in psychiatry and allied professions, was proposed last month as one way of easing the manpower shortage in the mental health field.

The recommendation was made November 10 by Richard P. Swigart, executive director of the National Association for Mental Health, at a national conference on the present status and future needs of mental hospitals. The conference, held in Washington, was called by Arthur S. Flemming, secretary of the U. S. Department of Health, Education and Welfare, and participated in jointly by Dr. Winfred Overholser, director of St. Elizabeths Hospital, only federally supported civilian psychiatric hospital in the country, and Dr. Robert H. Felix, director of the National Institute of Mental Health.

Mr. Swigart told the conference, attended by heads of 50 professional organizations, that he was convinced many of the thousands of volunteers who devote time and effort each spring to the Mental Health Campaign could with equal devotion pro-



vide more direct service to the mentally ill through their mental health associations. He pointed out that if funds are forthcoming NAMH is prepared to demonstrate, in a series of pilot projects in various cities, the wide variety of ways volunteers can supplement the professional care and aid needed by both hospitalized and homecoming mental patients.

Mr. Swigart also reported on the national conference on volunteer services to the psychiatric patient sponsored in Chicago last June by NAMH, the American Psychiatric Association, American Red Cross, Veterans Administration and American Hospital Association. It was attended by selected state mental health officials and volunteers representing major community groups serving the mentally ill.

Besides the serious personnel shortage, those attending the Washington meeting discussed three other topics of broad significance:

- The lack of adequate facilities and funds for the training of more mental health manpower.
- The need for improved communications between the federal Department of Health, Education and Welfare and the state and local mental health authorities.
- The importance of basic sociological research—on aging, for example—which sheds light on ways of preventing mental illness.

Morris Klapper, NAMH assistant executive director, represented the association and its affiliates November 3 at a similar federal conference on vocational rehabilitation. It too was called by Secretary Fleming and was arranged by Miss Mary Switzer, director of the U. S. Office of Vocational Rehabilitation.

Calling attention to mental health associations' deep concern with the employ-

ment problems of psychiatric patients, Mr. Klapper said NAMH proposes to spend a major effort in this direction for a long time to come. He pointed out that almost no state mental hospitals provide vocational guidance, job training or sheltered workshops for patients preparing to return to the community. And he noted that of 75 rehabilitation centers in this country which responded to a questionnaire, only a third reported they are satisfactorily serving ex-mental patients—though many thousands need help in finding jobs, homes and friends.

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A relatively unexplored concept—the communicability of mental and emotional illness—came in for discussion November 21 at the 5th annual conference of mental health representatives of state medical associations, held in Chicago.

Chairman of the discussion was Dr. Walter Baer of Peoria, a member of the American Medical Association's council on mental health, which sponsored the 2-day meeting. Other round-table groups considered mental illness and health in the aged, education for psychiatric medicine, the Joint Commission on Mental Illness and Health, and mental retardation in school children.

Dr. Leo H. Bartemeier of Baltimore, council chairman, presided at plenary sessions. Guest speakers included AMA president Gunnar Gundersen and Dr. Jonas E. Salk.

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A comprehensive program designed to aid the mentally retarded was recommended November 20-21 in New York at a meeting of the Council of State Governments. Sixty-five experts in health, education and welfare, including legislators from 30 states,

discussed ways of coping with mental retardation.

They urged especially that the retarded be enabled to enter institutions voluntarily, and criticized the stigma associated with court commitments.

They called for the establishment of diagnostic facilities in the community so that the retarded needing residential care could bypass the court and go directly from the diagnostic center to a school or hospital. They also urged careful study to determine whether an individual needed special classes or training, and called for permissive legislation making classes mandatory for those found educable.

Figures released at the conference put the number of severely mentally retarded at 1,600,000. An additional 3,200,000 are considered less severely retarded but seriously handicapped. More than 120,000 now receive institutional care.

The conference was organized by Sidney Spector, director of the council's Interstate Clearing House on Mental Health. The council, a research and advisory group created by the state legislatures and governors, serves as a secretariat to the Governors' Conference.

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More than 4,000 specialists in human behavior, including psychiatrists, psychologists, social workers and educators, are expected to attend the 3-day 36th annual meeting of the American Orthopsychiatric Association at the Sheraton Palace Hotel, San Francisco, beginning March 30, 1959.

This will be the first West Coast meeting of the AOA, which brings together the key disciplines involved in the team approach to prevention and treatment of behavior problems and related training and research.

A presidential session on the evening of

March 30 will include addresses by Dr. Linus Pauling, Nobel laureate in chemistry and professor of chemistry at the California Institute of Technology, and Dr. Weston LaBarre, author and associate professor of sociology and anthropology at Duke University. The presidential address will be delivered by Dr. Stanislaus Szurek, professor of psychiatry at the University of California Medical School and director of children's services at the Langley Porter Neuropsychiatric Institute in San Francisco.

A wide variety of topics will be covered in about 60 scientific papers and 40 workshop sessions, with emphasis on social and cultural aspects of mental health, treatment methods and research.

An all-day symposium is planned on brain and behavior, with the morning discussion centering on neuropsychiatry and neurochemistry and the afternoon on psychodynamic and social factors in brain damage.

Arrangements are being made for attendance by non-members, according to Dr. Marion F. Langer, executive secretary.

Among topics scheduled for discussion are research in maternal-child relationships, a study of high school histories of persons who later became schizophrenic and various aspects of schizophrenia in children and adults, sociocultural factors in mental health and illness, religious patterns as related to behavior, treatment of fathers of problem children, mental health programming in schools, mental health rehabilitation programs, therapy for children with school problems, therapy for economically deprived children with emotional disturbances, mental health aspects of prenatal health and prematurity, disorders in learning, problems of adolescence and juvenile delinquency.

Also evaluation of mental health programs and results of therapy, residential treatment programs, studies on hemophilia

and anorexia nervosa, drug therapy experiments with children and day care programs for severely disturbed children. Four sessions are planned to include mental health films and their discussion.

Exhibits of organizations and of materials related to the practice of orthopsychiatry will be on display during the sessions.

Further information is available from Dr. Langer, American Orthopsychiatric Association, 1790 Broadway, New York 19, or from the chairman of the San Francisco arrangements committee, Dr. Donald A. Shaskan, Veterans Administration, 49 Fourth St., San Francisco 3.

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The National Organization of the Institutes of Group Psychotherapy and Psychodrama will hold a 2-day session January 31 and February 1 in Detroit. For further information, contact Henry Feinberg, chairman of the program committee, 163 Madison St., Detroit 26.

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The American Society of Group Psychotherapy and Psychodrama will hold its next annual meeting April 25-26 in New York City. Papers should be sent to Hannah B. Weiner, 1323 Avenue N, Brooklyn 30, program chairman.

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The American Group Psychotherapy Association will hold its 3rd annual institute January 21-22 and its 16th annual conference January 23-24 in New York City. For further information, write to Dr. Cornelius Beukenkamp, public relations chairman, 993 Park Ave., New York 28.

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The 5th annual western regional meeting of the American Group Psychotherapy Association will be held April 2-3, 1959 in

San Francisco, with more than 500 psychiatrists, psychologists, social workers, educators and others in allied fields expected to attend.

Advances the past year in group psychotherapy will be keynoted in a paper by Dr. Martin Grothjahn of Beverly Hills, with S. R. Slavson of New York City as discussant. Mr. Slavson is credited with being the father of group therapy in the U. S. and the author of several books on group therapy. He is also editor of the *International Group Psychotherapy Journal*.

More than 17 symposia, workshops and general sessions will discuss such subjects as group counseling in a state prison, group therapy programs for family agencies, group psychotherapy for criminal offenders, family group therapy, therapeutic techniques in adolescents' groups, the recently developed transactional analysis, treatment of psychotic patients by group methods, and allied subjects.

Information on the AGPA can be obtained from Dr. Donald A. Shaskan, western representative, at the VA Mental Hygiene Clinic, 49 Fourth St., San Francisco 3.

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The largest delegations in the 8-year history of the National Association for Mental Health met in Kansas City in November for four days of workshops, business sessions and addresses by eminent speakers.

Coming at a time of increasing public insistence on adequate care, treatment and rehabilitation for the mentally ill, the 8th annual meeting and Mental Health Assembly attracted nation-wide attention to the importance of voluntary as well as public services for mental patients and their families.

Dr. Harvey J. Tompkins, 1st vice-president of NAMH and chairman of its pro-



professional advisory committee, formally opened the assembly Wednesday, November 19, with a report on latest developments in mental health and new concepts in aiding the mentally ill and their families. Dr. Tompkins was inducted November 10 as chairman of New York City's Community Mental Health Board.

Another feature of the keynote session was the introduction to the delegates of Dr. William Malamud, recently appointed director of NAMH research. Describing research as a key tool in the attack on mental illness, he said the new NAMH program would expand rapidly as more and more funds are allocated for laboratory work on the cause, control and prevention of mental disorders.

Following Dr. Malamud's address, Dr. John P. Horlacher of Philadelphia presented a formal report on the national conference on mental health education held last fall under the joint auspices of NAMH and the American Psychiatric Association. Dr. Horlacher, who served as chairman of the education conference, is a leading volunteer in Pennsylvania Mental Health, Inc., NAMH affiliate.

Miss Vivian Acord, public information representative for the Illinois Department of Public Welfare, was the principal speaker at a "get acquainted" luncheon following the opening plenary session. A former mental patient, she spoke feelingly of the value of day-in, day-out volunteer services, along with good public services, for the mentally ill.

In a dramatic ceremony during the luncheon the roll call of the states was conducted by the five regional NAMH vice-presidents: Augustus G. Means of Boston, G. Werber Bryan, Sumter, S. C., William W. Allis, Milwaukee, Mrs. Ernest R. Rector, Tulsa, and Irving Enna, Portland, Ore. The roll call was climaxed by the unveiling of the

1959 Mental Health Week billboard poster, showing the affectionate welcome given by a little girl to her father home from a mental hospital.

State mental health associations in Alabama, Louisiana, Ohio and Virginia were cited for achieving full status as divisions of NAMH this year, and the Maine association was honored as the newest provisional affiliate.

Still another high spot of the 4-day meeting was the banquet Thursday night with Adlai E. Stevenson delivering the major address. Speaking on "Our Mental Health Responsibilities in a Growing Democracy" he commented warmly on the growth of NAMH and its influence since he addressed the association's first annual meeting in Chicago in 1951.

Among the 700 guests attending the banquet were former President Harry S. Truman and Mrs. Truman.

In workshops Wednesday afternoon, all day Thursday and Friday morning participants discussed the variety of services provided by mental health associations to hospitalized and homecoming mental patients and their families. Film screenings and conferences on mental health education, community organization, fund-raising, public relations and volunteer services completed the work program.

Delegates transacted association business at sessions November 18 and 20, and members of the national board met November 18 and 21. NAMH president Luther Alverson of Atlanta presided at all sessions.

Social events, in addition to the Thursday banquet, included buffet dinners Tuesday for delegates from the five regions and a reception Wednesday night given by the Kansas City Association for Mental Health and the Kansas and Missouri state associations.

The assembly closed Friday noon with

a rousing "Ring the Bell for Mental Health" luncheon heralding the 1959 drive for funds. In a challenging speech Frank F. Elliott of Chicago, national campaign chairman, called on state and local mental health associations to double or triple their income next year, so as to be in position to meet the growing public demand for voluntary services to thousands of mental patients.

Citations and gifts—small gold charms in the shape of a bell—were presented to Virginia Graham and Margaret Whiting, co-chairmen of the annual Bell Ringers' March for Mental Health. Miss Whiting, unable to be present, sent greetings.

A special citation was also presented to the Connecticut Association for Mental Health for pioneering in the use of various fund-raising techniques, including the telethon and radiothon. Individuals honored were C. Marvin Curtis, Connecticut's campaign chairman; Sidney Burns, in charge of special events, and Louis Kaplan, staff assistant.

\* \* \*

The American Psychosomatic Society will hold its 16th annual meeting May 2-3, 1959 in Atlantic City.

\* \* \*

Dr. William S. Kroger, associate professor of obstetrics and gynecology at the Chicago Medical School, was elected president of the Academy of Psychosomatic Medicine at its recent annual meeting in New York City. Other officers are Dr. Maury D. Sanger of Brooklyn, vice-president; Dr. Bertram B. Moss of Chicago, secretary; Dr. Zale A. Yanof of Toledo, treasurer, and Dr. M. Murray Peshkin of New York City, historian.

Dr. Wilfred Dorfman of Brooklyn, president-elect, will succeed Dr. Kroger at the 6th

annual meeting of the academy next October in Cleveland.

\* \* \*

#### PUBLICATIONS

More than 125 new drugs have been tested or are currently under study in New York's mental hospitals. A number of the drugs already have been established as useful for special types of mental illness, according to Dr. Paul H. Hoch, mental hygiene commissioner.

New York was the first state to undertake a large-scale program with two of the drugs—chlorpromazine and reserpine—in 1955, after a full year of tests. Today 40,000 patients (45% of the hospital population) are receiving drugs as part of their treatment.

Under Dr. Hoch's direction over 300 full-time researchers are using, besides drugs, a wide variety of modern techniques in the study of psychiatric problems. Included are the electronic brain, electron microscope, radioactive isotopes, delicate types of chemistry and electronics, and brain wave devices permitting measurement within millionths of a volt or gram.

New York has also been hailed throughout the country for trying new techniques of hospital organization and operation, such as the day hospital and the unlocked ward.

These and other aspects of the state's total approach to public mental health are graphically described in a publication, *Design for Mental Health*, released recently by Dr. Hoch's office. Single copies may be obtained without charge from the Office of Mental Health Education and Information, New York State Department of Mental Hygiene, 217 Lark St., Albany.

\* \* \*

A tentative list of general hospitals accepting psychiatric patients for treatment, diag-

nosis or emergencies was circulated in October by the Joint Information Service co-sponsored by the National Association for Mental Health and the American Psychiatric Association.

To complete the list, those receiving a copy were asked to notify the JIS of additional hospitals that should be included. The list covers the U. S., its territories and Canada.

\* \* \*

Six hundred articles on mental hospitals are listed in a new pamphlet compiled by the American Psychiatric Association. They are categorized under administration, design, day hospitals, general hospital units, outpatient clinics, children's units, receiving hospitals, rehabilitation services, social structure, ancillary therapies, medical records, nursing services, follow-up care and equipment.

The pamphlet, titled *Selected Reading Lists on Mental Hospitals (1948-1958)*, also lists the names and addresses of pertinent journals, including *Mental Hygiene*.

\* \* \*

There's a manpower shortage in U. S. institutions for mental defectives, just as in mental hospitals, according to a report of the Joint Information Service co-sponsored by the National Association for Mental Health and the American Psychiatric Association.

The shortage, disclosed in an opinion survey conducted by APA's Central Inspection Board, shows up in eight categories of personnel. Officials of 84 hospitals and schools estimated they had only 55.9% of the doctors they would like to have, 48.9% of the nurses, 72% of the attendants, 47.4% of the psychologists, 40.7% of the social workers, 53.1% of the teachers, 21.2% of the occupational therapists and 29.5% of the recreational therapists.

The 84 hospitals and schools care for 94% of all mental defectives in public institutions. The opinion survey was the first step in establishing personnel standards for these institutions.

Findings of the survey are analyzed in Fact Sheet No. 7, published in September by the Joint Information Service and available from NAMH.

\* \* \*

The first two in a series of 10 monographs sponsored by the Joint Commission on Mental Illness and Health are off the press.

They are *Current Concepts of Positive Mental Health* by Marie Jahoda<sup>1</sup> and *Economics of Mental Illness* by Rashi Fein.<sup>2</sup>

Eight more monographs are to be published during the coming year. A final report of findings and recommendations for a national mental health program will be made by the commission in the latter part of 1959.

The third monograph, to be published this winter, will be a study of mental health manpower. The fourth, scheduled for publication in the late winter or spring, will report on a nation-wide sampling survey of mental health.

The Joint Commission was organized under provisions of the Mental Health Study Act of 1955 and charged with the responsibility of making a 3-year national health study. The commission is made up of 37 voluntary and government agencies interested in mental health.

Dr. Jahoda found that people define mental health in many different ways. In the present state of knowledge, she believes each is entitled to his own definition. As evidence, her published report contains a dissenting opinion from a member of the

<sup>1</sup> New York, Basic Books, \$2.75, 160 pages.

<sup>2</sup> New York, Basic Books, \$3.00, 184 pages.



commission, Dr. Walter E. Barton, Boston psychiatrist.

Dr. Jahoda rejects either "absence of mental disease" or "normality" as good definitions of mental health. She doesn't like the first because "mental illness" itself has not been acceptably defined, particularly in its milder forms, in certain character disorders and in anti-social and criminal personalities.

Normality, she says, tends to become synonymous with the average, or what the majority of people feel, think and do. But they do much that one would hesitate to call healthy, she points out. She notes that standards of normal behavior vary with the time, place, culture and expectations of the group.

In searching for a definition of mental health, Dr. Jahoda found that scientists who have done research on this question have used six different yardsticks in measuring mental health:

1. Attitudes of the individual toward himself (self-perception). The emphasis is on "being oneself," and on seeing oneself as he is, not confusing ideal self and real self.

2. Achievement of one's potentiality for growth and development (self-actualization). Mental health is seen as the product of striving for self-realization—of becoming what one can be.

3. A pulling or tying together of all functions in the individual's personality (integration). The integrated personality has an internal psychic balance and unifying philosophy that give life purpose and meaning, and hence considerable tolerance for stress, anxiety or frustration and a capacity of resilience or ability to recover from setbacks.

4. Individual's degree of independence from social influences (autonomy). The autonomous individual accepts parts of his environment and rejects others; he is able

to "be himself" and yet be part of "something greater than himself."

5. How the individual sees the world around him (perception of reality). Such perception is healthy when the individual sees what is really there, or what he sees is not distorted by some inner need, or he has a sense of how others feel.

6. Ability to take life as it comes and master it (environmental mastery). Here, success becomes the goal and adaptation a means to success. Ability to love, work, play, solve problems and meet the requirements of any situation is necessary.

Each yardstick presents one complication or another in applying it to everybody, Dr. Jahoda indicates.

She observes that the one value in American culture compatible with most approaches to a definition of good mental health appears to be this: An individual should be able to stand on his own two feet without making undue demands or impositions on others. This might be regarded as a minimum definition, although Dr. Jahoda hastens to point out:

"In the present state of our knowledge, perhaps it would be best to conclude that there are various types of mental health and that multiple standards can be applied to each. The genius and the moron and the average man may each have his own type of mental health."

Dr. Barton, expressing a typical medical viewpoint, dissents from rejection of the absence of illness as a criterion of mental health:

"Conceptually, it is difficult to see how a national program to reduce mental illness and increase mental health can be operated on any other base line than a straight one. In this continuum, illness is the point of departure and health is the goal. We work away from one and toward the other.

"If we had solved, or even partially

solved, the problems of preventing or treating major and minor mental illness, we could then justifiably concern ourselves with the issue of superlative mental health, or the degrees of goodness in good mental health. Unfortunately, we still have far to go in reducing illness. This is a practical concern, rather than a theoretical one."

\* \* \*

The cost of mental illness in the United States probably exceeds \$3,000,000,000 a year, Dr. Fein found.

He examined both direct and indirect costs. Direct costs included public and private expenditures for the care of the mentally ill and for mental health research. Indirect costs were hidden in the annual loss of production and income and in the loss of future earnings.

Dr. Fein estimates the direct costs at more than \$1,700,000,000 a year. The largest item is the care of patients in federal, state and county mental hospitals.

The probable minimum costs of private psychiatric care is estimated at \$100,000,000. It does not include the cost of care of patients with mental illness by general practitioners and specialists in internal medicine, believed to be between \$241,000,000 and \$1,205,000,000.

Dr. Fein estimates that patients in state and county mental hospitals and psychopathic hospitals annually lose 325,000 labor-force years with a dollar value of more than \$728,000,000. He computed, therefore, that the total direct and indirect costs each year exceeded \$2,400,000,000. But he noted that this total did not include private medical costs other than full-time private psychiatric care.

Judging from the discussion of low and high estimates of the cost of private medical care for the mentally ill, allowing for the fragmentary nature of the information

in this and in other directions, and fully realizing that certain omitted categories of costs cannot be estimated, the total direct and indirect costs of mental illness in the United States may be safely assumed to be in excess of \$3,000,000,000 a year.

Dr. Fein warns against an economic approach that holds large direct costs as undesirable and something to be eliminated, pointing out that the primary purpose of non-profit institutions is not to make a profit but to provide service and that, even in profit-making enterprises, costs need be minimized only to what is consistent with a given level of production.

In determining what should and can be spent for mental illness out of existing resources, he recommends the following economic reasoning as appropriate:

The only meaningful concept is that total costs comprise both direct and indirect costs. The nation bears the cost of mental illness whether it finances the direct costs or not. Economic considerations do not necessarily concern themselves with human or ethical values, but it is possible that increases in direct costs may reduce total costs. Measures reducing indirect costs are welcome, even though they may add to direct costs.

Dr. Fein refrains from attempting to tell legislatures where to find the money to meet the needs of mental illness as well as all other public needs, but suggests that an economy can afford to spend whatever it desires to spend. All that is necessary to spend more on one thing, he says, is to spend less on something else. What will be spent depends on the tax rate and the value system we embrace. The public and its leaders must make the choice.

\* \* \*

A new program aid for the use of mental health associations was distributed during a staff institute sponsored by the National As-

sociation for Mental Health November 16-18 in Kansas City. It is designed to guide the expansion of vocational rehabilitation services for former mental patients.

A rounded vocational rehabilitation program, according to the new publication, offers the patient counseling or vocational guidance, vocational training, an opportunity to develop sound work habits (in a sheltered workshop, if necessary), and aid in finding a job with an understanding employer.

The booklet was drafted by Morris Klapper, assistant executive director of NAMH. In it, he sets out the basic principles to be followed in organizing a sound vocational rehabilitation program for psychiatric patients. Sixteen reviewers (including several state and local mental health association executive directors) to whom the first draft was submitted commented favorably on both the material and the way it was presented, calling them "realistic," "sensible" and "very useful."

Mr. Klapper has proceeded on two assumptions: that rehabilitation starts on the day the patient enters a mental hospital and that the day of his discharge may be the most difficult one of all as he gropes his way back to health. Is he ready for normal community life, and is the community ready for him?

"This is the challenge to the mental health association," Mr. Klapper points out. "It is our job to stimulate both a climate and a pattern of community service which helps mental patients come back—ready to lead satisfying, self-sustaining lives—to communities ready to receive them."

In creating a favorable atmosphere for returning mental patients, Mr. Klapper notes, mental health associations will work in close harmony with state mental hospital administrators, state legislators and

state mental hygiene and vocational rehabilitation officials. Among other things, the associations can make a major contribution by helping these state agencies take full advantage of the variety of federal grants available for vocational programs.

It is also up to mental health associations to encourage community rehabilitation centers to extend their services to the mentally ill just as these centers help the blind, the crippled and the cardiac, Mr. Klapper writes.

Other avenues of service open to mental health associations are home-finding, continuous educational programs designed to break down industry's resistance to the hiring of ex-mental patients, and the recruitment of volunteers trained in occupational therapy, manual arts and specific aspects of the job market.

The booklet includes a short list of references and recommended readings, the names of the 12 advisers to the U. S. Office of Vocational Rehabilitation, and a brief description of 10 OVR-financed demonstration and research projects in the mental health field. Two of the 10 are going on under the auspices of the Massachusetts Association for Mental Health.

\* \* \*

A new 20-page document, first compilation of its kind, supplies information useful to all who are engaged in or planning child guidance clinic operations.

It is Fact Sheet No. 6 issued by the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health. The issue, entitled "Variations in Organizational Practices Among Child Guidance Clinics, 1955," summarizes reports from 95 member clinics of the American Association of Psychiatric Clinics for Children.



The study of selected clinics in various parts of the country shows such a wide range of variation as to indicate there is no "average" clinic for children.

"No attempt is made," it says, "to do anything more than give some indication as to the range of organization and practices possible in clinics which emphasize the team approach to the treatment—by well qualified professionals—of psychiatric problems in children."

The summary covers the financing of such clinics, the services they offer, the requirements for clinical services, professional and clerical salaries, fees charged and data on case loads.

\* \* \*

The proceedings of the 3rd Hospital Recreation Institute, co-sponsored last January by New York University's school of education and the National Recreation Association, have been published under the title of *Recreation for the Ill and Handicapped Homebound*.

The proceedings describe existing recreation services for the ill and handicapped who are homebound, and discuss ways of developing community resources for this group, of recruiting, screening, training and placing volunteers, and of using recreation to teach the physically or mentally ill.

Copies are available from the National Recreation Association, 8 W. 8th St., New York 11, for \$1.25 each.

\* \* \*

The September 15 bulletin of the Social Legislation Information Service briefly describes federal government activities on behalf of the aging as carried on by the Department of Labor, Housing and Home Finance Agency, Small Business Administration, Department of Agriculture, Department of Commerce, Treasury Department,

Veterans' Administration, Railroad Retirement Board and Civil Service Commission.

Programs of the Department of Health, Education and Welfare for older people were summarized in an earlier issue (No. 5).

\* \* \*

When skilled psychiatric aides have the qualifications for becoming professional nurses, they deserve all the help they can get.

Efforts of two New Jersey institutions to help aides get the professional education they need are described in an article titled "A Cooperative Plan for Bettering Care to the Mentally Ill" in the September 1958 issue of *Nursing Outlook*. The article was written by Miss Mildred S. Schmidt, consultant on the junior college nursing curriculum for the National League for Nursing, and Dr. J. Berkeley Gordon, chief executive officer and medical director at the New Jersey State Hospital at Marlboro.

Miss Schmidt was formerly director of the nursing school and nursing service at Monmouth Memorial Hospital School of Nursing in Long Branch, N. J., the school that accepts selected aides and prepares them for professional nursing.

Other articles in the same issue describe Ohio's residency program in psychiatric nursing and the place of mental health in the visiting nurse program.

In the October issue of the same magazine Dr. Richard Fleming, a psychiatrist, and Miss Winifred McLanahan, a mental health nurse consultant, tell how the staff nurses and supervisors of the Allegheny County (Pa.) Visiting Nurse Association went about adding mental health services to their repertoire. In the November issue the same authors present a number of cases showing how they were able to help staff nurses and supervisors provide more and

better services for emotionally disturbed or mentally ill patients and their families.

## REHABILITATION

Although Ohio's mental hospitals are now discharging more patients than they are admitting, many patients, unable to make their way in a hostile community, have to return to the hospital. To correct this situation, the Cleveland Mental Health Association has put 20 business men, vocational counselors, social workers and ministers to work studying methods of reducing readmission rates.

The committee learned that mental hospitals want help in finding new jobs for about-to-be-discharged patients, since less than half return to their former jobs. The committee also learned that being able to find and keep a job is one of the crucial tests of a patient's success in returning to the community. Among the factors affecting his getting steady work are the hiring practices and attitudes of employers, the patient's work record and ability to fit into a group, the support he receives from his family and counselors in the crucial days of job-hunting and beginning new work, and any special problems such as his need for time off for visits to the clinic.

Cleveland personnel executives with whom the committee has discussed the overall problem have recommended the publication of a pamphlet for prospective employers. It should stress, they suggested, the steadying effect of the tranquilizers,

experiences of employers in hiring former mental patients, and information by experts on what they can expect from patients they employ.

The committee believes each discharged patient should have the benefit of 5 aids in applying for a job:

- Group discussion before his discharge to help him build confidence and overcome apprehension.
- Discussions before his job interviews with someone outside the hospital, such as an employment counselor or social worker.
- An accurate record of his training and experience.
- First placement in a company with fewer than 50 employees, preferably one managed by the owner.
- Help to the employer in waiting out initial maladjustments that may arise.

"We see a serious need for further systematic study of the tranquilizing drugs and their part in the rehabilitation of mental patients," the committee writes. "Patients who formerly would have been hospitalized can now be kept going by the drugs outside institutions, but their grasp on reality may remain fragile. This poses problems for the community, both of accepting responsibility for the patients and of educating the general public about this situation."

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HENRY V. DICKS, M.A., M.D., F.R.C.P.

# Mental health in the light of ancient wisdom

*We have to see that the Spirit must lean on Science as its guide in the world of reality, and that Science must turn to the Spirit for the meaning of Life.*—CAREY BAYNES.

The trustees of the Mary Hemingway Rees Memorial have selected me for a signal honour—that of inaugurating a biennial succession of lectures devoted to the theme of mental health and spiritual values.

The gracious lady whose memory we—her many friends in the Federation—are thus perpetuating was herself the living witness to the harmonious blending of modern psychology and the religious faith of her fathers. At the corner of the street in which I live in London stands a solid granite church built by the piety and endeavor of Mary Hemingway's Scottish father, a church to serve the indomitable soul of her race as a rallying point in their diaspora in the far south of our island. Near the heart of London stands the Tavistock Clinic whose founding young Dr. Mary Hemingway per-

ceived as a challenge, as one of the original technical bases in our country of the new impulse towards mental health. She became a staff member from the inception of that clinic in 1920. It was here that she met a certain Dr. John Rawlings Rees, with consequences which all of us in the mental health field have reason to be grateful for.

If I have a qualification for this memorial lectureship, it is my long association and the privilege of friendship with Mary and Jack Rees, cemented by the common joy in the building up of the Tavistock Clinic. It is not easy to resist the impulse towards personal tribute to a great-hearted, charitable and serene woman from whom one has received numberless kindnesses, whose devotion to the ideals of her chosen vocation of

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Dr. Dicks, consultant psychiatrist of the Tavistock Clinic, London, presented this paper—the first Mary Hemingway Rees Memorial Lecture—before the 11th annual meeting of the World Federation for Mental Health in Vienna in August 1958.

medical psychotherapy one has closely experienced and of whose person one has been a warm admirer. Yet it is a more fitting, if more difficult, task to carry praise and remembrance to the point where our gratitude becomes transformed into learning, where the vanished relationship is internalized as enhanced understanding and our loss made good by the strength gained through our assimilation of the lessons of such a life as Molly Rees's.

I think it important at the outset of the first of a series of lectures, which will go on in perpetuity, to state the reasons why the founders of the World Federation for Mental Health, who knew her personally, felt it appropriate to commemorate her life and influence in this manner. In this way I hope to generalize and hand on the precious lesson to our successors and to friends in many lands, and perhaps sound the keynote on which successive future lectures will be variations and elaborations. The reason, surely, is the impressive demonstration to us, her contemporaries, of the strength and fruitfulness of personal and interpersonal integration in the service of shared spiritual values exemplified in the lives of our founding president and now director, Dr. J. R. Rees, and his late wife.

Now I am already deep into the main theme of my discourse. Can we doubt that a man whose role is instrumental, ordering and creating is sustained by the woman who is expressive, nourishing and cherishing? Was there ever a man who could bring forth change and new life in love of mankind that was not nourished from the undemanding, giving sources of his chosen woman, who thus affirmed and reflected his values, gave him strength and renewal, and sanctioned his mind's visions by her feelings? This is one level at which mental health fulfils both partners in a meaningful

relationship. To borrow from one of the oldest of wisdoms—this is the *Yang* and the *Yin* in operation in the married pair.

At another level, we have seen Mary Hemingway Rees integrating in her own person the physician and the wife and mother under the primacy of values derived from her strong Christian faith. In her youth this meant a very considerable achievement in fearlessness and autonomy. Not only for a girl to study medicine at all—but also after that to rebel against medical orthodoxy and enter the still suspect if not downright indecent field of analytic psychotherapy, at that time perceived as strongly subversive of moral values. Not only to gain success in this vocation but then to blend it with the feminine destiny of wife and mother, and emerge in the face of handicapping physical suffering as the wise, tranquil and gracious personality whose self-effacing sympathy and goodness many of us here assembled have been privileged to see in action. We all know what can and does happen under such possibilities of role conflict and of pressure from somatic factors, and so we are gratefully renewed in our faith in human resources when we see the precarious experiment succeed so well in a human being.

Here, then, is our subject exemplified in a remarkable personality. Mary Rees has set us speculating on a theme which is at the very core of the search for mental health. In wondering what was the secret of her personal integration and maturity, we are posing the problem she solved so gracefully by living it out. I should like to spell out some of the research questions we may hope to see answered in these memorial lectures which arise in my mind as the result of contemplating Mary Hemingway Rees's life and personality.



These are some of the questions one would wish answered as the memorial lectures unfold in the succession of years:

- What is the part played by spiritual values in the integration and maturation of the individual person and of human groups, notably the family group? And under what circumstances may spiritual values function in the direction of mental health for individuals and groups, and under what circumstances may they, if ever, hinder it?
- What must happen inside individuals to make this potentially powerful force active for the purposes of mental health and good human relations?
- Can systems older than modern behavioural science provide any guide to us who are endeavouring to bring about better mental and social health as to how *they* tried to solve this problem, and so set our modern principles and practice in historical perspective?

These are only a few of the possible basic questions. But even in these there is a challenge for any number of lectures and research projects. These could, for example, include statistical comparison of the incidence of every form of psycho-social disturbance in individuals and groups holding or not holding various types and intensities of spiritual values; spiritual healing; religious elements in transference phenomena; the nature of creative culture myths and beliefs; methodology of the study of religious and other value systems in individuals and groups, and so on.

You will note that in these questions and lists I have not even included the metaphysical problems of the reality or otherwise of the sources of such values, perhaps because in one's training in natural science one has been taught that this problem lies outside

the scientific realm. This in itself is already a value judgment, one with the slightly dated flavour of scientism—a vogue or fashion of the *Zeitgeist* which has us pre-occupied with control of the "how" of phenomena and tends to ignore the "why" and the "whither."

By contrast with this bleak "scientism" of our day it would seem most worth while to start our series by looking at some old teaching about the nature of man and his relation to his own being and to the macrocosm, which stands diametrically opposed to our Western science. I refer to the religious philosophies which have for over two and a half thousand years inspired two of the greatest civilizations—India and China—and shed their light into their neighbours' lands. I shall hope to show that, behind many differences, they have in common this concentration on a science and practice by which man is expected to become a fully developed, integrated person aware of being at one with the universal source of life and Being and freed from crippling partial loyalties. To those great religions Being and Becoming of men mattered supremely, social organization and action hardly at all. Theirs was an age of one kind of behavioural science—control of man's evolution from within himself.

I conceive that by beginning our series of memorial lectures with a glance at these ancient and still not widely understood systems we are not only paying our respect to venerable and profound doctrines concerned with our problem. We are also serving the purposes of a world federation to whom the great achievements and the future of every part of its universal membership is equally precious. And we are looking perhaps at our own ancient forerunners—namely, psychological systems meant to make men happy, free and good. Let me

hasten to add that I claim no more than a superficial acquaintance with my theme and acknowledge a profound indebtedness to those scholars on whose work I have freely drawn for my task.<sup>1</sup>

#### VALUES IN MENTAL HEALTH ACTION

The institution of these lectures on mental health and spiritual values is timely. As I stated in 1950, there is, in wide circles of our movement and our professions, almost a taboo on this subject. At our congresses the subject may be mentioned, a discussion group may be set up (and I believe Mary Hemingway Rees was largely responsible for such an innovation), but it is only very lately and rather drily that some social scientists have begun to examine the significance of values for the behaviour of individuals and groups. And these values are usually taken in a retrospective sense from the culture pattern from which an individual or a population under study has emerged, rarely from the more profound point of view of anagogic goals.

Yet it would be a piece of gross dissociation for any of us to pretend that we are neutral, desiccated scientists for whom all ideas are equal! At least we all have in our minds that mental health itself is a value—or we would not devote our lives and our energies to it. Everybody has some intellectual definition of mental health but few could give their full, inspirational sources—yes, their fantasy!—of the goal towards which they are working in pursuing their therapeutic or other mental health activities. I will say at once that I believe the values we hold are indeed very close to those which the major Eastern religious

philosophies have always represented as their central tenets. In these great oriental systems of thought and practice there was a foreshadowing of a faith in the possible unfoldment of humanity, which we here, and the circles who pursue the scientific study of mental health, are translating slowly into a possibility of mundane, concrete fulfilment. By way of analogy, ancient Democritus formulated an atomic theory, as part of a world picture, but it was left to scientists 2,000 years later to implement this by empirical research, and not only prove it but also apply it to the material universe and make atomic energy available for common use—good and evil.

So we, also, do what is an unprecedented new thing in the world: we try to promote and enhance human maturity and self-mastery on the basis of rationally intelligible concepts won in the empirical way by the exercise of technical skills. But the outline and the stock of ideas have been there through long ages. Even the most dilettante reading of such works as the *Bhagavad-Gita* and the Buddha's *Dhammapada* from India, or of the books on Taoism and on that most unique flower of Chinese Buddhist synthesis with Taoism, Zen, show how clearly these ancient masters saw the problems of what we would now call the unconscious and its relation to the total personality, and their developed techniques for making its treasures available in a balanced gracious life.

What we work towards—the goal value of mental health—is comparable to the old religious aspirations of “finding God,” of “salvation,” “liberation” and “perfection,” ideas which have moved men in all eras of history. At the more social level we have the vision of the “good society” or the “kingdom of God,” perhaps more typical of Western humanity. Even those of us who may be inclined to stress the social or

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<sup>1</sup> Notably the writings of Alan Watts, Dr. D. T. Suzuki, Shri Krishna Prem and Christmas Humphreys.

group aspect of mental health will scarcely deny that the ultimate reason for bringing about a peaceable, prosperous and enlightened world community is the provision of a milieu in which the human personality can enjoy full flowering, neither too individualistic nor yet a mere "number" in a kind of perfectly run human beehive. We want men to be happy, good and free. So did Gautama the Buddha, and Lao-Tsu.

Among the goal-values which are commonly held by the mental health professions, especially those concerned with therapy, I want to consider the chief three: the concept of adjustment, the concept of self-realization and the concept of integration of the personality. On each of these the ancient Eastern teachings have had volumes to say and thousands of years of practical experience in their pupil and teacher systems, which has produced human greatness in its most exalted forms, equaling and perhaps at its best even surpassing the mental giants of the Graeco-Judaean-Christian world.

## ADJUSTMENT

First, then, let us look at adjustment as a goal for men, as a target for the mental health worker—for himself and his clients. The stress in this concept is on man's reconciling himself to his society, on society as the centre and frame of reference. Adjustment can mean that somebody who is in revolt against his society should be brought to conformity with the norms, sometimes the therapist's own. Such a notion would make of mental health itself a norm, an average fitting into the current culture pattern and the local social values. Totalitarian institutions require that complete control over deviant thoughts and feelings: for example, the monotonous ideal of the new type of Soviet man reiterated in contemporary Russian literature or the stereo-

typed criteria we had to apply when, during the second war, we selected a variety of civilian men for suitability as officers. Again, the best "adjusters" to Nazi norms were not, as we now know, the most mentally healthy.

Charles Morris, the American philosopher, studied the preferences for different patterns of living and gaining fulfilment of various personality types. These patterns, even within one national culture, show a much greater divergence than that which our Western society regards as "normal." He concludes that the so-called "norm" cannot answer to the varieties of personality needs. He wrote: "A society adequate to contemporary men must be pluralistic enough to permit diversified lives appropriate to the diversity of its members. It must be zealous in the protection of those psychological minorities which we now disregard and maim. . . . It must have a new ideal of selfhood, shared by enough persons to furnish the unity without which diversity becomes chaos." In the *Gita*, the Lord Krishna says: "Howsoever men approach me, even so do I welcome them, for the path men take from every side is mine."

The first sample (and I can offer only samples) of Eastern wisdom concerns precisely this basic issue: a "new ideal of selfhood shared by enough persons to furnish a unity" without which there would be anomie, anarchy, chaos. For let us not forget that there is not only persistence but also loss of the old unities: of local identifications enforced by authoritarian rule, of external religious and social sanctions buttressing patriarchy and clan solidarity and conformity. These are being swept away by secularization and technical revolution. Modern man is both in revolt against these old authority systems and unhappy without them, not knowing by what light to live. Adjustment of the individual to norms was



appropriate for a period when conformity to stable, generally accepted values was a condition of survival. Men still crave for restoration of authority over them, and are easily led back to subjection. This invites the power-holder, be he priest, politician or psychiatrist, to exercise his power over his flock, to coerce, cajole or persuade them—and especially the deviants—to the prevalent pattern.

This is the injury done to individuals even though they ask for it. Whether done in the name of religious dogma, or political ideology, or therapeutic norm, this concept of adjustment always contrasts a "we" who know what is best with a "they" who are in sin or in error or in sickness. It is an expression of dualism, of the existence of opposites, with the subject in the good position and the other in the bad position. Forms of coercion are invented to make people obey the Sermon on the Mount or the rules of Confucius. Children discover good and evil by reference to rewards, prohibitions and punishments. From the pre-ambivalent unity of the infant we enter ambivalence and the conflict of opposites.

It is from this painful and conflictful dilemma of coping with this ambivalence, with the struggle between love and hate, submission and rebellion, that the great teachings of the Indian Vedanta offer deliverance: the *Bhagavad-Gita* is one of the purest condensations of them, and the doctrine of Gautama the Buddha, himself born an Indian, is built on them. How different from conformity is the call in the *Gita* and in the *Dhammapada* to forsake idolatry, to develop the self and put one's faith in one's own destiny. It is an assertion of the possibility of every man to know his inner self and to find that it is one with the divine nature. "He who seeth Me everywhere, and seeth everything in Me, of him will I never lose hold, and he shall never lose

hold of Me." (*Gita*, sixth discourse.) Again: "Look within, for Thou art Buddha." "Work out your own salvation with diligence." "Each man his own helper, each his own host."

What becomes of the goal value of man's adjustment to his environment at the hands of such teachings will be taken up later. First we must look at our other two postulated modern mental health values: self-realization and integration.

### SELF-REALIZATION

This concept, often heard from the mouths of persons in mental health work, has for me a meaning opposite to that of "adjustment." It is akin to "individuation" or "personal liberation." It carries many overtones which one connects with the aims of psychoanalysis: to free the flow of man's energies from the obstacles of infantile or culturally-induced fixations, to help him find his identity and make him unafraid to affirm it. In the process he will experience a sense of falling away of shutters or confining anxieties and, so to speak, wake up from his nightmares. All religious or spiritual teachings have had much to say on this subject, and they, as well as our own experiences in analytic work, have made us cautious of the dangers inherent in this aspiration. It can be another form of "self"—opposition to the "other," to the external environment, a false or spurious self-liberation, inflating *hybris* or self-centred pride in defiance of others and of the values of society. It is a narcissistic aim which reminds us of those people, whether in religious life or in our consulting rooms, who hunt after personal salvation, omnipotence and freedom from social constraint—the *sacro egoismo*—and believe that they will find health and happiness that way. If the search for "adjustment to norms" is a concept of ascetic giving up of too much self-

will, then "self-realization" is its opposite—the escape from the pain of group responsibility and self-limitation.

The traditions and words of the ancient masters were unanimous in unmasking the self-inflation hidden in such striving, just as the modern analyst will become aware of the deep hate contained in the imperious wish of his patient to share the secrets of power and happiness he believes the therapist to possess. It was a misunderstanding alike of the aims of *yoga* of old and of analysis of our day to accuse them of working to bring this about.

It has often been mistakenly assumed and stated that the great Indian and Chinese religious systems advocate precisely this achievement of a self-centred, world-denying condition, that they have turned the individual away from facing his worldly responsibility, that, in other words, they are guilty of the very error we have just spoken of—of forsaking and despising the world. Reading about them, one can see how this has come about, just as a perusal of the works of Christian mystics and quietists might lead to similar conclusions about the central tenets of the Western faith. Though the impressions left on many Western readers by the writings of Indian and Chinese sages seem to be directed at achievement of self-realization in the bleak, salvation-seeking manner I have indicated and letting the world go hang, in fact they are essentially concerned with something other than this—something close to our third goal value for mental health.

## INTEGRATION

Integration is a concept capable of reconciling the two goals of adjustment (to the society and its shortcomings) and self-realization. I have elsewhere proposed a definition of integration as "an event in the personality resulting in the pooling or

synergism of its energy resources hitherto polarized so as to neutralize each other." This involves something of the Hegelian idea of synthesis from thesis and antithesis; of the idea of the person as a total self, emerging from resolution of conflict; not the little self which Freud called the ego with its defenses and rationalizations, nor yet some deeply hidden virtue residing in the "unconscious" unilaterally released—but in the harmonious interaction of both systems as one, in the form and life of the whole. In this matter modern dynamic psychology seems in much closer agreement with the Advaita doctrine of Vedanta, with Buddha's doctrine of the Middle Way and with the concept of the Tao in Lao-Tsu's teaching than with Christianity (unless the latter is read in a very mystical, rather unorthodox way). Advaita means "not two." The world of form and the world of the spirit are the same. It is true that at one extreme this doctrine degenerates into spiritual monism and nihilism—"nothing is real except the Absolute" . . . "all forms are illusion." But against this is the wonderful passage: "In darkness are they who worship the world alone, but in greater darkness they who worship the Infinite alone." The infinite has no meaning apart from its opposite—the finite. Its meaning is that these two are one, and that one is the whole—Brahma. The world of form ceases to be illusory when the many become the One. Light is, when energy meets resistance—as witness the current and the filament of the electric lamp. Vedantist and Buddhist alike hold that "the formed and the formless are one; the mortal and immortal, the definite and the indefinite." Buddha's principle of the Middle Way lies in the understanding and implementation of this unity in opposition. The Tao, also, is the unifying principle behind the *Yang* or masculine and the *Yin* or feminine,



whose union in interaction is life, constantly changing and elusive.

We in the West have so far not got far beyond thinking in antinomies. Even in our modern psychology we have tended to take our various patterns of this dualism without resolution of the conflict. When speaking of man—the microcosm—it makes little difference whether we call the opposites love and hate, good and evil, or God and Satan. There is much in common between these, and with Freud's early formulation of the "good conscious ego" and the primitive "anarchic" id. We still quarrel over the reality of mind as against matter as the only reality. This has a very real bearing on our whole approach to human conflict.

The former position is rare in Western medical philosophy, but it finds expression in Christian Science. The latter position—"the darkness of those who worship the world alone"—is that of scientific mechanism, which leads to a logical cul-de-sac, namely, the futility of its own formulations as meaningless "epiphenomena" of mechanical cerebration. Mechanical therapy can be its only result in medicine, while in the wider sense it leads to the Franckensteinian madness of coercing nature and less powerful human beings.

At a certain level, then, the ancient wisdom of the East had already foreshadowed our growing insight into the human problem of projecting onto the world picture the state of its own growth and maturation, which runs from non-differentiated potential through polarization or differentiation back into consciously realized fusion or reconciliation of the opposites—from pre-ambivalence through conflict into integrated person, in modern terminology. The dualism which characterizes Western man's view of the mind:body problem (or, at cosmic level, the God:perceivable universe

problem) can be held to be an index of the state of our psychological evolution. The Eastern wisdom can accept my statement in this form without a wince. Western religions have had trouble over Darwin until quite recently. The Eastern position is based on the idea of a single underlying Reality behind a multitude of forms issuing forth from it, differentiating themselves through aeons of time (quite *a la* Darwin) and seeking to return. This Reality is Aldous Huxley's Divine Ground. The illusion is that we are ever separate from it, that there is opposition between us and the Ground, that life is polarized into mind and matter—and the reality is their inseparable unity which is the spirit or life, flowing on, endlessly.

The effort, therefore, of the Eastern religious systems is to heal this illusion of separateness, the inner ambivalence, to bring about that event in energy resources and which they would call something like enlightenment or finding the spirit. If human development is as we have reason to think it is, then ambivalence was and is as great a source of emotional pain in the East as it is in the West. Only the Eastern philosopher's concept of its fundamental cause or ethical base is rather different from ours. Their philosophy does not oppose God and man or God and the universe. (This is the great error or illusion for them.) They are seemingly polarized for the sake of the development of self-realization and differentiation of the human spirit. The achievement, the finding of the self, is contained in the discovery that this differentiation was, as it were, part of the Infinite finding itself again in full awareness in a myriad minds.

The act of creation is stated thus in the words of Brahma: "Having put forth a portion of myself, I remain." In another passage, we read: "Know My other nature . . . the life-element, . . . by which the universe



is upheld. Know this to be the womb of all beings. I am the source of the forthgoing of the whole universe and likewise the place of its dissolving . . . I the rapidity in waters . . . I the radiance in moon and sun . . . sound in ether, and virility in men; the pure fragrance of earths and the brilliance in fire am I; the life in all beings am I . . . Know me as the eternal seed of all beings. . . ." (*Bhagavad-Gita*.) Enlightenment is the coming to rest at the hub of the revolving wheel of life, is finding the centre.

#### ACHIEVEMENT OF INTEGRATION

It is not easy to convey the quintessential spirit of what the Vedantist, Buddhist and Taoist teachers advocated to the man who sought wisdom and liberation from oppressive inner conflict in some secure resting place of the soul, much as a patient might consult us today, and to convey it honestly, not overpainting the similarities or minimizing the differences. To begin with, let us not be put off by the fact that the instructions in numerous books and texts of 2,000 years ago are cast in religious terms, when all science and the world image were subsumed in these, or that they take for granted the reality of reincarnation, of the aeons of evolution before a given soul, risen through prehuman form and many rebirths to the point where it is searching for its liberation, asks "How shall I be saved, escaping the pain of lonely world existence?"

In very broad outline, the answer is not, as many Westerners as well as many of their own believers think, "Flee the evil world, mortify the body, sink yourself in a trance, and contemplate the Eternal." So far as one can tell, certain disciplines and exercises were prescribed much as an aspiring musician must do scales and arpeggios or an analyst must practice free association

and observe his dreams. The excesses of some of wild self-mortifying fakery drenched with ash were as the excesses of Christian fanatics and anchorites in early monasticism. The answer was rather something which Gautama Buddha termed "The Middle Way," and which in China was known as the Tao.

Re-reading some of the essential literature again, one is surprised at the likeness to the aims and interpretations in present-day analytic therapy. The teachers and masters who knew what they had achieved and what they were talking about were at pains to get suitable individuals to see that the things of this world or about themselves were only disgusting or evil by what they called "attachment" to them, but in reality all were manifestations of the one divine self. All things were informed of this one life. A man had only to break through the barrier of his clinging to infantile self-gratifications and of the inevitable guilt that went with it to realize his own union, to reconcile his little ego and the universe (including his own nature) in a new integrate, to gain a vantage point at the root of the pendulum so that its swings from one side to the other, from self to non-self, were no longer beyond his cognizance and control. In this way man, instead of standing against the world in rebellion or in awe of external gods and demons of his own invention, learns that these are part of him, just as he is part of the world, that his reason—his ego—and his natural needs can be on the same side, living life.

To us this is part of developmental theory. The infant cannot yet distinguish body from ego, and projects and introjects the world freely in fantasy. Moral development, mental maturation, consists not only in separating these opposites, in knowing what is inside and what is outside, but also in gaining insight into the differences be-

tween the reality principle and the pleasure principle. It is almost certain that the Buddhist call to robust autonomy and self-reliance, to abandon the hankering after external saviours and magical helpers is imbued with an understanding of "attachment" in the sense of looking for gratifying parent figures in the world. Buddha says: "Be ye lamps unto yourself." "Look not for refuge to anyone but your own selves." "Hold fast to Truth as a lamp." "My action is the womb that bears my destiny." "By his own deeds a fool is tormented." "Purity and impurity are things of a man's inmost self. No man can purify another."

Admittedly there are great differences of emphasis in the varied interpretations which this great doctrine has inspired, just as there have been in the religious differentiations and divisions of the Christian and Moslem worlds. In the many branchings from the tree there has been none more surprising in its living, timeless spirit than the blend resulting from Buddhist impact on ancient China's Tao doctrine—the strange and fascinating tradition of Chan, better known by its Japanese name of Zen.

Whereas the *Gita* and its restatement by the Buddha gave rise to the most complex and abstruse speculative systems and austere practices, very akin to world-denying asceticism, Zen appears to have distilled the essence of the vivifying, life-affirming message, we might say, in defiance of any rational theology or metaphysic. It is the ancient equivalent of our most modern psychoanalytic concept: that of the Here and Now. It proclaims by paradox and by the rediscovery of the beauty and unity of life and of nature in perhaps the world's greatest art—its lights and its shadows—that the secret of the universe is contained in acceptance of everyday reality and a fresh viewpoint on commonplace tasks and

situations. I will try to illustrate this in a moment.

We may be pardoned for being frightened and appalled by the austere demands of the *Gita*. Here the liberation of man from pain and conflict is portrayed as residing in what is called giving up "attachment." There is to my view in this doctrine a close analogy to our modern concept of breaking a "fixation" and to the therapeutic goal of maturation by freeing the mind of its immature, ambivalently invested seeking for infantile objects of gratification. By continuing to view the world and present human relations through the distorting lenses of projection of these early ambivalent object-relations, we are carrying the dependence, the infantile demanding, prejudiced, angry unconscious attitudes and feelings forward into adult life. In order to "adjust" to the demands of reality the ego adopts the various mechanisms of defence: repression, identification, re-projection and similar anxiety- and guilt-laden checks on emotional life, which in consequence remains stunted and deluded. As the Eastern sages knew as well as ourselves, one of the outcomes is a false, super-ego morality, covering inner secret rebellion, leading to such phenomena as neurosis, delinquency and its socio-political analogues. Pseudo-religiosity and hypocrisy may be among the symptoms of this split in the personality. The *Gita*, in one notable sentence among many, puts this neatly: "The abstinent run away from what they desire but carry their desires with them; when a man enters Reality he leaves his desires behind him."

Essentially Buddha taught a similar psychology of emancipation from "desire"—perhaps best translated as "wish" or "infantile demand." Gautama was very aware of guilt and retribution (*karma*)—a kind of self-induced hell of Nemesis that follows

anti-social sexual or sadistic behaviour. His aim was certainly to be done utterly with this kind of unconscious ambivalent thirst for exploiting the object and to replace it by inner realization of the futility of hanging-on, of hoarding and keeping unreal objects of desire. He, like St. Paul, wanted to "put away childish things," realizing the impermanence of all that is, and to live to express the Becoming which is the action of the opposites in the manifested universe. Thus can man feel a conscious part of eternal evolution.

As those who have read *The Secret of the Golden Flower* (introduced to us by C. G. Jung and his commentary) will know, Chinese Taoist religion has a very similar basic concept—that of the unity in opposites which interact to make life slowly perfect itself. Taoism emphasized the limitations of mere morality: from a primordial mystical undifferentiation "the Tao was lost and there came duty to man and right conduct." This is none other than the Fall of Jewish doctrine: the knowledge of good and evil makes man polarize the opposites and so resort to defensive virtue. The quest for integration, for reconciliation, is the finding of Tao. Whereas in the Indian world this quest led to the proliferation of subtlest metaphysical-theological system, in China it led to the perhaps still subtler metaphysic of laughing at these pomposities of high-brow thinking, at becoming the slaves of our own rationalizations. So there is not that forbiddingness about Chinese as there is about Indian deep religion. The Tao is brought to birth in us when we cease to "think about" Truth, or to mortify ourselves, or to burn incense before idols; when, instead, what Christians might call grace quietly dawns, when we suddenly see in a flash what all the bother and conflict and striving has been about. It is that "We

are what we have been all the time." Now is this "self-realization" or is it "integration?" Perhaps it does not matter. But it is a reconciliation between man and his universe—man and God—and man and his worst fears too.

Zen, which arose in China as an experience of this blessed state, which those who had it wanted to communicate to whom they could, is best described by this paradoxical anecdote. A Chinese sage, asked "What is the Tao?" replied: "Usual life is the very Tao." He was asked: "If that is so, how do we bring ourselves in accord with it?" The reply came: "If you *try* to accord with it, you will get away from it." At a certain stage, man realizes that theory is of no avail, that theology and metaphysics are no longer important, that they satisfy only his curiosity for a unifying hypothesis *about* the universe and his place in it. They had been necessary to provide him with a base from which to secure a justification for right living.

It is like the need of the child to have a good and clear start with precepts given him by his parents for helping him to deal with his primitive needs, until he can fashion his own, when he must break free. We know how such parental and cultural precepts and deep beliefs can later stand in the way of living life, of grasping experience and its meaning immediately instead of indirectly through the parental values, the stereotypes of convention.

The nearest Christian equivalents for Zen I have to offer (and I doubt not that there are much better ones) are the doctrines of grace and the symbols of the "lily in the field" and of the "kingdom of God within us."

A Zen master, asked where the enquirer could find the Buddha, replied: "It is very much like looking for an ox when you are



riding on one." (This is perhaps why one so frequently sees Chinese sages depicted in sculpture and painting riding on oxen.) A similar pointer to the paradox of Zen experience is this: "If you strive after Buddhahood by any conscious contrivances, your Buddha is indeed a source of eternal misery." Alan Watts says about this: "When we dress in the morning, eat our breakfast, shake hands with a friend . . . this is all full of Zen. It is worth more than all the sacred scriptures in the world . . . , for what are they but enormous commentaries about this one thing which is life? At this very moment all of us are living Zen, and the only difference between ourselves and the great sages is that they realize it and we do not." Hence the words of the Zen poet Hokoji: "How wondrously supernatural and how miraculous this—I draw water and I carry fuel!" "We say 'I live' and the Zen master says 'I live.' The difference is that we have a barrier between the 'I' and the 'live,' whereas he has not."

So such a modern writer as Lin Yutang has written: "I do not think any civilization can be called complete until it has progressed from sophistication to unsophistication . . . and I call no man wise until he has made the progress from the wisdom of knowledge to the wisdom of foolishness, and become a laughing philosopher, feeling first life's tragedy and then life's comedy." This, he assures us, is the fruit of his people's understanding of the synthesis of life.

So also Lin's ancestors, cultivating Zen, have again and again found that what they had been seeking in ideas and books, in moral severity and self-mortification and meditation, had been with them all the time. Life had up to this flash of discovery been like a stupid dog chasing its own tail. "Nothing is left to you at this moment," writes a Zen philosopher, "but to have a good laugh."

In this moment of enlightenment (which the Japanese called *satori*) all the solemn, self-important, angry beating of one's head against a brick wall, all the unconscious *hybris* and wishes for omnipotence, the childish craving for the magical secret, resolve into the insight that there never was a secret that the hostile world withheld from one; that one wasn't any longer the angry rebel or the timid conformist chasing a projection of an unloving God or parent whom one must propitiate or defy. This is a profound religious experience, and results in a new sense of identity and oneness with life. It becomes impossible to want to hurt or force anyone any longer. That infantile desire is dissolved in this moment too.

#### EASTERN THOUGHT AND DYNAMIC PSYCHOLOGY

While the experience of Gautama at the moment of such enlightenment transfigured him into a Buddha and thus ended the need for a further earthly career, we need not conclude that the prescription for the achievement of enlightenment, of *satori* or integration relates only to the sublime level of mastering the unconscious. We cannot guess at what this may mean in a possible world of reality, even though we have, I hope, laid aside the most arrogant of all assumptions—that there are no higher states of knowing reality than what we now know. Enough for us that the concepts and principles are of value to us *here and now*. In the classical period of the great Eastern systems it mattered supremely for men to achieve this knowledge, just as in the last few hundred years it has mattered supremely to Westerners to conquer nature, space and gravity. Their emphasis was at the cost of ignoring the problems of social and economic organization in the world of forms, ours at the cost of the neglect of the

universe of meaning and spirit, each thinking we were the wisest or the most progressive. But now, just as the East has embarked on a technological and social revolution to bring its ancient civilizations closer to the West, so we, on the threshold of mastery of the physical universe, have begun to seek the remedy for our one-sided development. Again—on the principle of polarization and differentiation—we could not know that we could not find integration this way until we had climbed the heights in technical achievement without finding peace or happiness. The West is reaping unparalleled prosperity and physical well-being, but its neurosis and delinquency rates are mounting. "What shall it profit a man to gain the world and lose his soul?" It now matters greatly for us to know how to find our own souls. It is here that I perceive to be the value of the new, raw, groping discipline of dynamic psychology, rooted in biology and medicine. Freud<sup>2</sup> and those that followed him can already point to genuine resolutions of opposed energy systems in the personality through analytic therapy. Synergism and cessation or diminution of conflict results from a humanizing of the super-ego and from an upward flow of the previously repressed, banished forces of the id towards syntony with the thus strengthened ego. It is one of the truly happy experiences of the therapist to witness the flash of *satori*, of insight, when such confluence occurs in a human being—often accompanied by just that wonderful laughter of which the Zen masters spoke. It is followed by an increase in vigour and reality sense. In the course of time there also occurs a corresponding change in the person's relations with his environment. The new integrate does not have to project what he feared in his own unconscious objects onto a world opposed to him in fantasy. That is what I would call readjust-

ment. It is not to norms or to old defensive super-ego morality; it is to what was formerly feared and hated but is now seen as but part of ourselves. The adjustment is to psychic reality, disclosing a changed world picture. If we can be the midwives of such events—events which the wisdom of India and China knew also long ago—then surely the ultimate aim of our movement is to do all we can to make it happen often, everywhere, in many human beings.

I do not mean this to imply just more and more psychoanalysis of sick individuals. The process can be paralleled also in the progressive integration of social groups into new entities manifesting new qualities and powers different and superior to their former parts who do not thereby lose identity. The tension of the opposites in the social as against the intrapersonal field is displaced to outgroups, to the "opponent." Our equivalent of analytic therapy is not yet fully apparent, but can be thought of as the "resolution of group tension," and its techniques remain still largely a research goal. The ancients had not got that far either.

Enough has perhaps been said to support my belief that in our new behavioural sciences lies our own modest but exciting beginning of that higher turn of the evolutionary spiral, when ancient, exclusive, recondite *yoga* becomes analytic insight and psycho-dynamic management towards integrating persons within themselves and with each other, and so reconciling them to life in its ceaseless flow and change. That indefatigable fellow worker of ours, Lawrence K. Frank, said ten years ago in London: "We need to develop a field theory of human nature and society which will relegate to the history of ideas many of the older dichotomies and antinomies which

<sup>2</sup> In whose city this lecture was presented.



view men as always fighting against society, or man as the tool of society, or man outside nature, or society as a superhuman power or mechanism ruling over men, and similar expressions of now obsolete ideas." To this list I would like to add the prevalent idea of God—the recipient of every kind of loving and hating anthropomorphic projection men have cared to hang on to the Unknown Source of Being, and all but abandoned by men, not even realizing the projection, as incapable of answering their childish demands, as the unattainable object. As psychoanalysts (as well as many others) would agree, we are indeed in danger of destroying ourselves by super-ego morality, by our own reactive defense mechanisms of compulsive virtues and partial loyalties, under which lurks the wish for rebellion and retaliation without a cause. Outraged nature is taking revenge for its debasement and denigration during a long epoch of history—no less in the ascetic East than in the puritan West, equating the sexual needs and the manifestations of the self-assertive tendency of the human child with original sin while placing a god in a distant heaven.

Recent work in psychoanalysis has shown that the primary, pre-ambivalent dispositions of a child, not yet introduced to restraint and sin, are as much those of love and the desire to give as those of greed and the wish to take. Thus the observations of Melanie Klein and her group infer the existence of a natural morality which reacts quite early with anxiety and despair to its own aggressive fantasies against loved objects. Here lies an important clue to the origins of what the East projected on a cosmic scale: the opposites of creation and destruction, of love and of hate rooted in the social-biological dependence of the human being on its dimly perceived givers of good nourishing things, destined to diffuse

into conflict and contradiction (Buddha's desire, the Gita's attachment), and capable, as we now know, of highest flowering or basest self-undoing, according as we now maintain or resolve this fateful battle of light and darkness.

By the very metaphors we use we can see that we are still bound semantically and emotionally to a conviction of dualism, even though we begin dimly to perceive what the integrative union, existing unperceived in deeper reality from the beginning, can mean for the release of love and creativeness in man, whether we call it God or Nature. Zen, the flower of the Eastern evolution of religious science, has foreshadowed this highest kind of human achievement. And it has done so by apparently superseding all that is commonly understood by religion, substituting for it that for which religion has searched—the direct experience of release from bondage of inner contradiction between good and evil, suffering and conflict, here and now, by accepting life in all its aspects because it is of the same nature as its source.

And now we, the youngest and most rudimentary of the sciences of man, have come into possession of an art and a theory which can release these same latent values in Western mankind. Not by aping the East, but in our own way, we have begun to mediate between the opposites in man—his reason and the tabooed rejected part of life, the dirty, untamed, inarticulate gropings of nature in the babe towards selfhood. There are still those to whom this discovery of humble beginnings, of roots in the earth, presents a humiliation and a threat, to be overcome by force or denial. Not for them the gentle wisdom of our longest human civilizations which have never tried to force others to their beliefs. Not for them the most beautiful of Eastern symbols: the lotus, nourished in the mud, climbing



through the dark waters of the emotions until it raises its opened blossom to the light.

At heart I believe that the pattern of life itself is ever striving to such completion, until on the opened lotus appears the serene, childlike shape of the man of perfect compassion in the attitude of benediction. There will be many aeons before our work will be brought to fruition, before we shall see mankind living as Gautama enjoined: "As a bee collects honey but injures not the flower—so let a wise man dwell on earth."

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# Relatives' attitudes and mental hospitalization

In the recent literature of mental hospital practice a great deal of attention has been given to the way various features of the hospital environment affect the patient (7, 8, 9, 12). At the same time, although to a lesser extent, some attention has been given to those factors which affect a patient's adjustment after he has been returned to the community (1, 4, 6, 11). However, extra-hospital influences on the hospitalized patient—particularly the attitudes of relatives—have received but scant attention in the literature. Observations by those who work with relatives of patients have increasingly suggested that these attitudes may be a fac-

tor in maintaining the illness and prolonging the hospitalization.

When a psychiatric patient is hospitalized his relatives develop distinct attitudes toward the illness and the hospital. Indeed, even before hospitalization the relatives have begun to develop special attitudes toward the illness, since the onset of illness frequently occurs some time before hospitalization. With hospitalization, these attitudes become more explicit, and are elaborated to include attitudes toward the hospital treatment program and the hospital's responsibility in the custody and care of the patient. The present paper is a preliminary study of these attitudes.

While this study is not concerned with etiologic questions, it is based on the assumption that the development and main-

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Mr. Rose is a case supervisor in the social service department of the Veterans Administration Hospital in Bedford, Mass.

tenance of psychiatric illness is influenced, in part, by emotional ties among family members, that is, the extent to which they have strong emotional involvements with each other. The psychiatrically ill member brings about changes in the behavior and attitudes of other family members. The removal of the ill member through hospitalization brings about further attitude changes, distinct from those which were apparent when the ill member resided in the home.

The present study of relatives' attitudes was undertaken in the social work service of the Veterans Administration Hospital in Bedford, Mass., since the hospital presented unusual opportunities for such a study. In the first place, the hospital was situated close to the population centers of eastern Massachusetts, making it possible for many relatives to maintain contact with the hospital. Secondly, the hospital has admitted patients for the last 30 years, thus providing a setting for the development of prolonged hospitalization. Furthermore, the social work service has over the last decade accumulated considerable experience in delineating and dealing with relatives' attitudes, through its casework program both during and following hospitalization.

#### METHOD

For this exploratory study a representative sample of the relatives of the hospital population was sought. Accordingly, every tenth patient of the hospital population as of November 1, 1955 was taken in order of admission since the hospital opened. This procedure yielded 180 cases. This sample was found to be representative when it was compared with the known distribution by age, sex and diagnosis of the total hospital population. The relative participating in the study was defined as either the principal

visitor (the one who visited the patient most frequently between November 1, 1954 and November 1, 1955) or the patient's next of kin as listed on hospital records, if his relatives did not visit him.

Eighty cases were lost from this sample of 180 cases, leaving 100 cases as the final study sample. The 80 cases were lost for the following reasons:

- In 36 cases the relative refused to cooperate in the research interview. (These were largely relatives who did not visit.)
- In 21 cases the relative lived at a prohibitive distance for an interview to be arranged. (These relatives did visit but infrequently.)
- In 11 cases there was no known relative.
- In 6 cases the patient went home regularly on passes and leaves of absence and was out of the hospital a good deal of the time.
- In 6 cases the patient left the hospital after November 1, 1955 and before the research interview took place.

An examination of the remaining 100 cases revealed that they were similar both to the total hospital population and to the final 10% sample as to age, sex and diagnosis. As might be expected from the above, there was, of course, one difference between the 10% sample and the final study sample—in the study sample relatives visited somewhat more frequently.

The relatives were contacted through an initial appointment letter and one follow-up letter or telephone call. The initial letter was worded as follows: "Through our social service department, the hospital is interested in improving its service to the relatives of our patients. A member of our social service staff would therefore like to talk with you, when you next visit the hos-



pital, concerning your views and suggestions, which would be very valuable to us." In response to this, 80% of the relatives came to the hospital for the interview. A home visit was made to the remaining 20% who were unable to make the trip to the hospital.

The two sources of data were interviews with relatives and hospital records. The object in both the statistical and interview material was to get information bearing on relatives's attitudes, interests and feelings.

The interviews were relatively unstructured to best bring out the feelings of the relatives. The interviews were usually begun with more neutral material, such as attitudes to the hospital, the treatment program, the personnel and the visiting. Through such general discussion the feelings of the relatives were explored indirectly. Later in the interview the relatives tended to express specific feelings quite spontaneously. Thus, after a discussion of the more neutral areas of hospital, personnel, visiting and so on they were able to proceed to the more personal material concerning the treatment of the ill member, the cause of his illness, and their feelings about taking the patient home when he was better. Often when the relatives discussed mental illness and psychiatric treatment in general they inadvertently revealed their attitudes toward the sick member. In some interviews the more personal material could be gleaned only by inference or by the associative sequence of material within the interview.

The interview protocols were analyzed in an informal content analysis. The attitudes selected for presentation were those found to be characteristic of the study sample as a whole. A particular case is cited only when it is representative of a group of such cases.

## PATIENTS' CHARACTERISTICS

As in any large established mental hospital, the population at Bedford contains a group of long-hospitalized patients. Thus, in the 10% sample the median age was 50 and the median hospital stay was 9 years. In the study sample the median hospital stay was the same although the median age was only 44. Many of the older patients had to be excluded from the study as they had no living relatives.

The percentages of non-psychotics and those with organic psychoses in the study sample paralleled those found in the total hospital population. Four percent were non-psychotic, 14% had organic psychoses, and the remainder—the functional psychoses—were largely schizophrenic.

## FREQUENCY OF VISITING

In the initial 10% sample 22% of the patients who had relatives received an average of at least two visits a month between November 1, 1954 and November 1, 1955. In the study sample 35% of the patients were visited twice a month. The lower figure in the 10% sample was due to the fact that relatives who visited infrequently or not at all were more apt to refuse to be interviewed or lived at a prohibitive distance for an interview to be arranged. As might be expected, older patients and those with longer hospitalization had less frequent visits from relatives. These relationships are shown in the table.

If one regards visiting as an index of interest or concern for the patient, it would appear that such interest or concern diminishes with the patient's age and continued hospitalization even when relatives are living, as is the case in the study sample.

The cases in the 10% sample that received visits were rated as to which relative was the principal visitor. In addition, the

VISITING FREQUENCY	MEDIAN AGE (years)		MEDIAN YEARS OF HOSPITALIZATION *	
	10% <sub>0</sub> SAMPLE	STUDY SAMPLE	10% <sub>0</sub> SAMPLE	STUDY SAMPLE
Received at least 2 visits a month	36	35	2	2
Received less than 2 visits a month or none at all	56	54	11	10

\* From time of last admission

comparative visiting frequency of the principal visitors was determined. The percentage of cases in which each relative was rated as principal visitor and the percentage of cases in which each principal visitor visited at least twice a month are summarized in the table.

As can be seen, the mother was most often the principal visitor, a reflection in part of the fact that most patients were single. Second to the mother was the sister. In all cases where the sister was the principal visitor, the mother was deceased or too aged and infirm to travel. It was fairly obvious that the sister in these cases was taking over the mother's role in visiting. The low rank of the father may be explained on the basis that he tends to be the oldest relative and does not live long enough to take over the principal visiting role of the mother in the same manner as does the sister.

In addition to being most often the principal visitor, the mother also visited more

frequently than other principal visitors. Though the father was seldom the principal visitor, when he was he was second to the mother in visiting frequency. It is noteworthy that as principal visitors mothers and fathers came to the hospital more frequently than wives. Since married patients were younger and had shorter hospital stays, one would expect their wives to visit them relatively frequently in accordance with our general finding that short hospital stay is associated with more frequent visiting. Wives' visiting, however, no doubt diminished earlier than parents' visiting since they had other obligations such as the care and support of children. Yet, wives did visit more often as principal visitor than sisters and brothers.

#### REACTION TO THE INTERVIEW

There was a consistent reaction of defensiveness to the request to participate in the interview. This was evident in those who

PRINCIPAL VISITOR	PERCENTAGE OF CASES IN WHICH RELATIVE WAS PRINCIPAL VISITOR		PERCENTAGE OF CASES IN WHICH PRINCIPAL VISITOR VISITED AT LEAST TWICE A MONTH	
Mother	28		57	
Sister	22		17	
Brother	13		11	
Father	10		38	
Wife	10		29	
Other relatives	17		0	

refused the interview as well as those who cooperated. In correspondence and telephone calls with those who refused, the relatives presented themselves as aggrieved parties (either in relation to the patient or the hospital) and enlarged on why they could not take the patient home. Relatives who did participate in the interview were apprehensive about "some trouble." They were afraid that the patient had done something wrong, or that something terrible had happened to him, or that they were going to be asked to take the patient home—all this despite the initial letter to them which clearly explained the research purpose of the interview.

In the interview itself, anxiety was considerably alleviated when the interviewer further explained that the interview was not for the purpose of taking some action in their particular case but only "to make a survey." They found the role of helping others through participating in a research project was gratifying and reassuring. This effect did not relieve them entirely of their anxiety and defensiveness but it did make it easier for them to stay with the interview.

#### ATTITUDE TO VISITING

The relatives were asked in the interviews whether they thought they were visiting often enough. Their own feelings in this regard usually did not correspond to their actual visiting. Furthermore, a given rate of visiting would be considered frequent by one relative and infrequent by another.

Those that visited infrequently were defensive about it and felt that the hospital, friends, other relatives and the patient expected them to visit more. Moreover, they tended to exaggerate or were vague about the frequency of their visiting, or invoked as excuses realities of time, distance and money. An example was a wife who visited

once a year but felt that she was visiting at an adequate rate.

Those that visited very often were also defensive since they were afraid the hospital might consider their visiting to be excessive. They minimized the visiting frequency and glossed over reality limits of time, distance and money. A typical example was the aged mother who faithfully visited every week by public conveyance and from a distance, yet apologized because she was not visiting often enough.

In a third of the interviews the relatives reported the visiting experience as unpleasant, often describing the patient as insulting or unresponsive. These negative reports usually came from relatives who visited infrequently, but a good many also came from relatives who visited frequently. Some of the major reasons for visiting appeared to be:

- A sense of duty.
- A fear of criticism from relatives and friends.
- To ward off feelings of guilt and rejection from having a family member in the hospital.
- The need to continue control of the patient. An example was the mother who was proud of having been a faithful visitor for many years and who, in her own eyes, was devoting her life to taking care of her child in the hospital.

#### ATTITUDE TO HOSPITAL

In general, the relatives had lavish praise for the hospital: "The hospital is a wonderful place" or "God bless the hospital for the wonderful care they give." The hospital was regarded as the authority in the care of sick people and this relieved them of the burden. Relatives were hesitant to



criticize the hospital because they didn't want "to get in trouble with the authorities." Also, they did not want to engage in any criticism which might disturb the *status quo*, and lead to their being asked to take the patient home. Only in rare cases did the relative say, "The hospital is a prison" or "The patient is getting worse the longer he is here."

It is noteworthy that while there was little criticism of the psychiatric care, there was criticism about the bodily care of the patient. This criticism was of food, clothing and personal hygiene of the patient. Another group of criticisms were characteristically unreasonable: "The patient should have his own radio" or "The hospital should completely cure my boy" or "Fights (and injuries) among patients shouldn't happen."

A frequent and significant belief expressed by the relatives was that the hospital had "taken over" the patient. This idea was both welcomed and resented, although it was welcomed more than resented.

In general, relatives felt that a gulf separated them from the hospital. They professed to know less about what was going on in the hospital than they actually did. Relatives who visited frequently were more capable of offering constructive criticisms and suggestions. Nevertheless, these relatives basically felt unrelated to the hospital and were similar in this respect to relatives who visited infrequently.

There were the exceptional cases of relatives who had to have complete control of the patient's environment. They visited several times a week, fed the patient, clipped his toenails, inspected his hair. These relatives in addition might even attend the weekly dances held for patients in the evening. Such relatives seemed almost like

patients in the way they identified with the hospital and seemed to be experiencing the patient's role vicariously. Unconsciously, perhaps, they were seeking help by exposing themselves to the hospital. They related, however, to the custodial rather than the therapeutic aspects of the hospital. Thus, the hospital as a treatment institution was even to them a hazy and unknown entity.

#### ATTITUDE TO PERSONNEL

Relatives generally expressed an interest in having more contact with the hospital personnel. When they were specifically asked how much contact they had, a surprisingly large number—about half—admitted that they had fairly regular contacts with the staff, particularly the nursing assistants. Whereas relatives had little criticism of the hospital in general, they had more to say when asked about their attitude to personnel. Their negative feelings were particularly directed to the nursing assistants' physical care of the patients. This criticism was strongly transference-laden in that relatives viewed the nursing assistant as parental surrogates—a fact to be borne in mind when considering the membership of a therapeutic team dealing with relatives' attitudes.

While initially relatives were reluctant to admit their contacts with the hospital personnel, they subsequently admitted having contacts and even voiced a desire for more contacts. They asked how this might come about and, when told, were grateful for the information or admitted they already knew. The writer's impression, however, was that merely informing relatives of their opportunities to talk with the doctor, social worker and nurse was not the solution. It appeared that the relatives did not know how to make the contacts they said they wanted

because they were not predisposed, or actually feared to do so. They were, in a word, ambivalent about their working relationships with the hospital. They were resistive to receiving help and yet showed by their behavior their need for help.

#### ATTITUDE TO TREATMENT

Relatives professed having little understanding and knowledge of the patient's activities and treatment regime. They had a feeling of distance from the hospital, felt uninvolved in the treatment of the patient, and abdicated to the hospital the responsibility for the patient. When questioned further about their knowledge of hospital treatment they revealed more awareness of treatment, especially somatic treatment, than they had originally indicated. They knew more about drugs, shock treatment and treatment for physical ailments than they did about such psychotherapeutic approaches as individual and group psychotherapy, and rehabilitation activities.

A relative's professed ignorance of psychological treatments may be related to his denial of the emotional factors in the patient's illness. An illustration of this was the mother of a patient who had fractured his leg 10 years ago while in the hospital. This mother insisted that the last 10 years in the hospital were solely for the treatment of the fractured limb, ignoring the more serious psychiatric disability. When she was asked how she would feel about taking the patient home, she quite dissociatively launched into a lengthy and well-documented history of her son's psychiatric symptomatology.

The relatives' feeling of non-involvement in patient treatment militated against their receiving help from treatment personnel. Even when social workers and doctors tried to work with them they tended to be resistive and to discourage such efforts. In ad-

dition, they avoided personnel they thought would try to bring about a change in them. Another factor operating to keep relatives and treatment apart was the hospital's policy of focusing on the patient, and the relegation of work with relatives to a very secondary position. The relatives used this reality to justify their feelings of "apartness." Their familiar cry was "Nobody tells us anything." But behind this innocent sounding complaint was a complex hard-to-treat problem.

#### ATTITUDE TO PATIENT'S ILLNESS

As already mentioned, the relatives tended to deny the existence of mental symptoms. Their characteristic explanation was as follows: The patient came here for a rest, and he was "all right" as long as he was here; but if he left the hospital, he would not be "all right." Hospitalization, then, was used as an aid to deny the presence of illness, and was necessary, apparently on a permanent basis, to maintain this denial. The relatives gave the basic impression that they were mystified as to how the illness was manifested, how it was to be treated, and what caused it.

There were three answers to the specific question as to what they thought caused the illness: "don't know," "the war" and "a physical cause." The three answers occurred with about equal frequency.

Those who blamed the war stated, "Before the war Johnny was perfect, but he returned completely changed. Therefore, the government should cure him or take care of him." They were hazy as to the specific circumstances in the war that caused the illness. In some cases they did specify, stressing somatic factors such as a physical injury, heat, malaria, or other infectious disease. Relatives frequently referred to the fact that the government had adjudicated the illness as being caused by

the service. They were, however, just as apt to blame the war even when the illness was not rated as service-connected. The relatives showed tremendous guilt and disturbance over the illness and were very much predisposed to project responsibility or blame. The war served as a clear-cut, as well as a respectable, explanation for the illness.

The somatic explanations seemed to be part of the relatives' effort to find a simple, concrete, understandable reason for the illness with which they would not be personally involved. By relying on a somatic explanation they were able to avoid more disturbing feelings. The quest for a "simple" somatic explanation was dramatically illustrated by the relative of a patient afflicted with Parkinson's syndrome. The relative believed the condition was due to hemorrhoids.

In the instance of relatives who were not closely related or involved with the patient there was more willingness to consider psychological factors. For example, a stepmother who had recently married into the family, ascribed the illness to a "lack of love, security and understanding."

The relatives were asked what effect the illness had on their relationships with family and friends. The majority stated they felt no stigma and were able to discuss the matter with others. This might be due to three factors: Their own conviction of the somatic basis of the illness, the current community educational program regarding mental illness, and the special community acceptance of mental illness in veterans.

There was less impact on the family life of the primary family than on that of the conjugal family. Since the majority of the patients were single the over-all effect was not grave. Even with married patients, the wives seemed to have made successful adjustments in raising children, in working

and living with other relatives. In fact, the relatives' adjustment improved the longer the patient was hospitalized. Free mental hospital care and veterans' pensions to the family also mitigated the effect of the mental illness.

#### ATTITUDE TO PATIENT'S RETURN HOME

Relatives commonly interpreted the interview appointment as part of the hospital's attempt to get them to take the patient home. They therefore spoke of their feelings on this matter even before the interviewer asked: "Would you take the patient home when he is well enough?" The answer immediately given was "yes," in a scandalized tone, as if the question impugned their integrity and loyalty to the patient. But immediately following this answer they voiced questions and doubts. Characteristic responses were "I have no room," "The patient is not ready," "There is no one to watch the patient," "The patient is well taken care of here" and "The patient might choke me in my sleep. He is harmless but you're kind of scared." Relatives consistently evaluated the patient in terms of his current status, not in terms of possible future improvement. If the patient had recently improved, the relative evaluated him in terms of his pre-improvement status. This denial of improvement, or the potential for improvement, was expressed especially by the relatives who denied that the illness existed.

In a few mothers the denial of the illness had the opposite effect. They wanted to take the patient home no matter how sick he was. Many of them in the past had taken the patient home and provided constant care and attendance. Such patients remained home in an unimproved state sometimes for years. These relatives would reluctantly return the patient only because



of community complaints or because forced to do so by another member of the family. They visited the patient very frequently in the hospital and were always willing to take him home again. They showed even less awareness and understanding of the illness than those who could see the patient only as a permanent hospital resident. Some of these latter relatives also visited very frequently, but for the purpose of "taking care of the patient in the hospital."

While the relatives of the long-term patients resisted the idea of their patient coming home, this was not true of the relatives of the few short-term patients in the study. The reaction of these relatives was more positive, hopeful and flexible. The reorganization of family life had not yet been completed; the patients' hospitalization was still considered temporary and their place in the home was still open. On the other hand, in the case of the long-term patients, the relatives' attitudes showed the adverse effects of prolonged hospitalization. These relatives had reintegrated their personal and community life without the patients, and the patients' place in the home no longer existed.

## CONCLUSION

This exploratory study examined the attitudes of relatives that were associated with prolonged hospitalization. A sample of an existing hospital population was studied which contained a large group of patients who had been unable to leave the hospital. Thus, the study was focused on the failures of the hospital rather than on its successes.

The analysis of the findings on relatives' attitudes showed that relatives felt dissociated from the hospital and its treatment program; they regarded the hospital as a custodial institution rather than as a psychiatric treatment setting; they had diffi-

culty in seeing the illness as a psychiatric disorder; they felt hopeless about the illness and resisted the possibility of improvement and, finally, they "closed ranks" in the home against the patient's return (3).

While these findings are in need of further delineation and study, they do point to the need for a hospital program designed to deal with the amelioration and prevention of these attitudes. A preliminary study is now underway on the applicability of the child guidance model for dealing with relatives' attitudes. It is common procedure in the child guidance setting to treat the parent as well as the child (5). A somewhat similar arrangement should be possible when a patient is admitted to a mental hospital (2, 10). It would be part of the hospital admission policy for the relatives to enter out-patient treatment. This treatment would be aimed at the prevention of attitudes deleterious to the patient's recovery and disposition.

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## Patients and profits

The hospitals no longer have an unlimited source of cheap labor.

It is even suspected that the few patients assigned are sometimes required to work long hours seven days a week, to help show a paper profit.

How many patients are available for farm work? Could patients be assigned to other areas in the hospital? If they are reassigned will the new activity be of equal benefit? Just why do you need a farm when your job is to treat patients? Does the farm show a profit? If so, how is this possible when your farm employees work 40 hours a week and receive paid vacations and sick leave?—Granville L. Jones, M.D., "Should State Hospitals Stay in the Farming Business?" *Mental Hospitals*, 8 (November 1957), 21-22.

# Children-- lost and found

A friend of mine is emotionally disturbed. No more immune to tension and stress than the rest of us, he has lost a sense of direction and has become sick in his mind, in his heart and in his feelings. His problems have sapped his courage and he has chosen the affliction we call mental illness as a means of making his problems bearable. The disease is a kind of way out of his fears, indeed the only route his sick mind tells him is left.

He was a functioning part of our world until the day came when he could no longer cope with his problems. Then he began to see our kind of life as an insurmountable

threat to him and, paralyzed by fear of what he felt, he made a life of his own within himself. He will be hospitalized until he is strong enough to abandon his protective dream and accept our world as his own once again.

Just now, as a patient in a psychiatric hospital, there is little to distinguish him from other emotionally disturbed persons sick enough to be confined.

Except that he is a child.

I was aware that mental disease had no respect for boundaries set up by man, but like most well-intentioned persons I never had realized that a child too could live in the bleak borderland of the mentally ill. Yet Sandy, Karol and the other youngsters I met this year have known mental disorder. I worked with them as they learned

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Mrs. Lyons writes with skill and perception about the children she cared for as a ward aide in the Nebraska Psychiatric Institute, Omaha.



how to get well, and in this work I have seen that an individual's grapplings with himself and with his surroundings are part of a battle that may be fought and won, and fought again, before he is old enough to go to school.

I had already decided to work as a ward aide in the state-sponsored psychiatric institute near my home when I learned that the hospital had a children's unit. Certainly the concept of mental disease in children was new to my thoughts. While the idea of working with normal children was pleasant enough, I wondered what it would be like to deal with disturbed, lost youngsters every day. The question lodged in my mind and I found myself challenged by it. When an opening on children's service occurred, I applied for the job.

Behind the surge of normal enthusiasm I felt for a new job, however, lay nagging uncertainty.

Introspectively, I wondered if the work I proposed would lead me to a ghost world as dissociated from the vitality of my own sphere as life is from death.

If, indeed, the disturbed youngsters sick enough to be hospitalized were habitants of a dove gray death-world where shadows moved and spoke in censored idiom, where only "safe" persons and objects were recognized by the sick child himself, then where would I be useful? Would I be able to help these children realize that the living world I know can be more attractive than their self-constructed world of flight? My ideals had given way to doubt, but I decided to take the job anyway and contribute to it what I could.

The few psychology courses I had taken in college had led me to believe that work with the mentally ill was a wide-open field, a challenge to those who could meet its test. I was convinced that most of this testing would be in my reaction to my patients

and in theirs to me. It was they who would be acutely sensitive to whether I passed scrutiny. If I found myself able to love these young patients, and to accept them as fully as I accepted myself, the work would be the experience of a lifetime.

The hospital plant where I was to work was only a few years old, and the children's ward I had visited when I applied for the job was impressively clean and new looking. The youngsters had been off the ward, in recreational therapy, when the director of nurses took me through the area. What I saw that afternoon chased away many of my notions about the world of the mentally ill being a kind of soundless limbo.

Here were crocus-bright halls, restful green and brown bedrooms, a rosy-warm lounge. All was as suggestive of life and light as spring and sunshine.

A small tennis shoe, stray markers from a Monopoly game and the remnant of a pop-gun gave evidence of tumultuous life going on in this ward every day. Only the children's presence was needed to give animation to this scene.

I looked down the quiet hallway, experienced the convent-like stillness of the ward lounge on my tour, and I wondered. . . .

Now all was serene on the ward. I felt self-contained and at ease. But what would it be like when thirty emotionally disturbed children were assembled here? How would I react to thirty behavior problems? Beginning to realize how mistaken I had been in thinking of psychiatric patients, particularly when they are children, in an equation with silence and shadow, I began to feel that I would be anything but poised when confronted by these youngsters.

Walking on the ward that first morning of work, I felt a little self-conscious in virginal white from head to toe. I had felt capable

and adequate in front of my mirror the day before, when I tried on my uniforms. Today I was apprehensive.

It was only a little past 7:00 in the morning, and I got but a glimpse of the dozen or so in-patients. (The day-patients would not arrive until 8:30 or 9.) Looking at them later from my vantage point in the nurses' station, I remembered what the director of nurses had told me. She had explained that these were sick children, as disabled as if polio rather than emotional problems were the enemy they battled.

Tolerance was in her voice, and acceptance and love, when she explained that outward signs of this sickness might be defecation, smearing, even the crude curses so often difficult to accept in a child. Unusual behavior of every kind might be expected in these disturbed youngsters, she went on. She indicated that fears—fear of rejection, even the fear of love itself—might cause or further aggravate the manifestations of the illness.

But, as I was later to learn in ward classes, the children would one day learn to exchange fear and flight for love and self-acceptance.

When this day comes to the child, he is well.

Now it was time for "orientation to the ward," and I followed the young nurse assigned to acquaint me with my surroundings. The first thing we came to when we stepped out of the nurses' station was the ward lounge. The presence of the children made it seem a study in contrast to the same quiet parlor I had visited only a few days ago. Several youngsters, finished with breakfast, had clustered around the television set. Sprawled in the various double-jointed attitudes that only children can assume, they appeared engrossed in this morning's offering by Captain Kangaroo.

Among them were the more sedate figures of nurses, aides and an orderly.

Outward calm prevailed for the moment, but before long a dissonance played counterpoint to the television. It began with a low murmur and soon swelled into the strident cacophony of angry young voices. My eyes traveled to a corner of the lounge where two 10-year-olds were having it out, both verbally and physically. Some disagreement evidently had led to a wrestling match and the two boys, flushed and angry as bulls at bay, fought as if by an unwritten code. No ordinary provocation here, I thought, as it became obvious that far more angry feelings than those the two boys held toward each other were involved. Expressions of anger, resentment and something else were in their faces, making them look as I have seldom seen even adults look.

A small cheering section had formed, and cries of "Chicken! Chicken-fighter!" were heard as one of the boys violated the tacit rules of the fight.

Goaded by the taunts of his peers, young Sandy, the "chicken-fighter," turned from the specifics of his wrestling match to the jeering group near him. He was deeply flushed and sweat glistened against his skin. Anger had seemed to constrict his throat as he rasped out a challenge and a curse to the spectators near him.

"You cheat!" he roared to those who had accused him of a similar breach. "You all cheat. You gang up on me and it's not fair . . ." The boy danced in his rage, and he would have seemed ludicrous had I not seen the mounting passion within him as he went on with his tirade. He seemed possessed by his emotion now as he swung blindly at the nearest patient. An orderly was about to intervene when Sandy's storm broke and in tears he abruptly left the area.

I wanted to find out more about the incident but it was time to visit another part of the ward. Feeling as if I had walked into the middle of a movie, I was puzzled over what I had seen. Why do they have to fight so hard, so unreasonably, I wondered.

As the months passed I was able to gain insight into this and other incidents by attending the weekly ward classes conducted by a staff doctor on children's service. In this class, and in another weekly group session with the ward supervisor, I began to see that with my two fighters, and in a vicarious way with their small audience, a young lifetime of feelings had perhaps come to the fore during the fight and the ensuing upset. It was as if a normal, boyish way of settling a dispute had been used to act out painful, pent-up emotions . . . feelings about situations which might have little to do with the surface disagreement but which bubble like boiling water under a tight lid. Those of us who are not sick find acceptable, even constructive ways to release uncertain waters that churn within us. We remain well because our safety valves are in working order. However, for reasons native to each case, these youngsters seem not to have discovered their special valve, or perhaps the safety release has become clogged and useless. As the healthy avenues close off, the child begins to grow sick inside. The pressure swells and must find room within. When there is no more space to contain and control this force the young patient seems to find his only solution—in mental illness. If by nature he is an especially aggressive child, in his illness we find him full of fight and bluster. Like Sandy, the "chicken-fighter," he shakes his fist at a world he sees as fickle and unfair. If he is of a more timid nature, we find in him the desire for flight rather than fight when he

becomes sick. He seems to cower and cringe until his arc-light of communication is confined to a lonely beam inward.

I saw an illustration of the contrast between angry patients like Sandy and the frightened, withdrawn patients like Lanny and Tim as we approached the boys' wing on our orientation tour.

In the exact center of the hall twirled a young dervish, minus only the baggy pants of the costume to complete the picture. Arms outstretched, hands clasped, lips in a compressed smile, 7-year-old Lanny spun round and round, never seeming to become dizzy, never straying from the pinpoint area of floor he occupied.

In charting this behavior, as we did several times daily in the hospital, we might have referred to it as "inappropriate" and "not relating to the group." Generally, I considered these psychological terms to be classic understatements, and in association with this little boy, "disconnected" was the word that more specifically came to mind. He had a private orbit on the ward, and I was frequently struck by the abstract loneliness of the path Lanny traveled. He seemed so completely frightened by every person, every stimulus around him that he had withdrawn to another, safer place within himself, literally severing his thoughts from contact with daily life. When one of us did get close to him he wheeled off into his silent dance or, as a final weapon of defense, produced bowel movements with incredible frequency. Only the most heroic of the staff members could withstand these onslaughts of feces when making an effort to get through to Lanny. I was to see the patient's awareness increase to the point where he could show at least passing interest in the colored pictures of a magazine and could feed himself without smearing half his dinner into the table-top.



of crying when her wails went unheeded in the slovenly boarding home that had housed her since birth. This baby who came to us had forgotten how to cry. She lay on her back, silent and pathetic, scarcely able to lift her head. Anna had lived nearly half a year, yet the scales showed her only slightly over her birth weight. Doctors' examinations had shown no physical cause for her condition. Ward orders for her were simply to give her as much cuddling and cooing, as much mother-love, as possible. We all spent every available minute giving her the affection for which she was starved, and in three months' time she was sitting up unaided, laughing at our efforts to amuse her, crying vigorously when the need arose and gaining weight every week. The pity I originally felt for this infant has been exchanged for the pride we all felt in her when we learned she would soon be ready for normal adoption.

These varied reactions to our "little children lost" are perhaps less positive than the one response which has grown to surpass all others. As the months pass, the feeling flourishes and matures like the love of mother for child. Quite simply, it springs from being able to help fulfill the thirsting need of a stunted youngster to grow again.

In ward classes held for the aides and orderlies every week I have learned to utilize my own assets and emotions in helping our sick children acquire health. Expert, trained assistance is always at hand to help us know our patients, and indirectly to know ourselves so that we will be of maximum value in our role. Some of the classes are devoted to learning all that is pertinent in the background of specific patients. In an effort to learn something of "how they get that way" we discuss sum-

maries of the child's home life, situations in the past which may have had a traumatic effect.

In other classes we partake of a kind of group therapy, where each of us on the staff agrees to respect the other's confidence so that we might speak honestly of our individual problems with the patients. These sessions, sometimes lively with argument, are like the functioning safety valves I mentioned earlier: by frankly discussing our methods in dealing with ward situations, and our inner thoughts about these actions, we learn to read our own hearts with knowing eyes. We begin to recognize the "why" of our feelings and with this self-knowledge comes significant understanding of the patients. Perhaps in this area lies the keynote to satisfaction in my work.

As much as I think I give these youngsters, in empathy and in love, they give in return, to the fullest measure. Even as we have helped the children grow, so they, in their acute perception of us, permit us to grow with them. Is it worth the occasional indignity to the adult spirit, the less than astonishing pay, the minor hurts to pride, the exasperations, the fatigues, the tensions? Growth, at any price, is worth it for the children . . . and for me. Like the parent who fosters independence in his child and foresees the time when that child has grown enough to leave the nest, I feel a pang at the departure of the youngster to whom I have given much.

But this sense of loss is the signal of my reward. Only when the youngsters have received enough from us to be able to leave us can they be considered nearly well. And the patient's wellness, his long-awaited growth, is our final pleasure. As the child has matured, so have we.

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ELAINE CUMMING, Ph.D.

JOHN CUMMING, M.D.

# Two views of public attitudes toward mental illness

It is possible to look at public attitudes toward mental illness from many vantage points. We are attempting here to synchronize an academic sociological analysis with a practical therapeutic one in the hope of better appreciating the social context in which therapists work to mitigate the suffering of the mentally ill. We have, in the past, successfully used this double-barreled onslaught upon the stubborn problem of the relationship between the mentally ill person and the society from which he has been ejected.<sup>1</sup>

A sociologist, by definition, is trained to analyze problems from the social perspective. He does not, of course, question that mental illness is primarily a personal and interpersonal problem, but he focuses upon

its impact on society. It is to him a special case of the social control of deviance, which is itself one of the all-pervasive problems of social living, and it is in this light that he analyzes it.

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At the time this article was written Dr. Elaine Cumming, a member of the faculty of the University of Chicago, was completing a research study of mental health in Kansas City. She has since been appointed to the post of sociologist in the New York State Department of Mental Hygiene, for which Dr. John Cumming directs a research unit in Syracuse.

This is substantially the text of a 2-part speech delivered by the authors March 27, 1958 at the annual meeting of the New York State Society for Mental Health.

<sup>1</sup> Cumming, Elaine and John Cumming, *Closed Ranks*. Cambridge, Harvard University Press, 1957.

Opinions and attitudes about how deviance should be controlled are variable; not only are there more than one set of acceptable attitudes toward deviance at any one time but there tend to be long-term trends of change in these attitudes. During these long-term changes we in the mental health movement often sustain quite serious losses. We lost a lot, for example, with the shift from moral to medical treatment of the mentally ill, and currently we may even be losing some very humane skills for handling disturbances because our revolt against the "custodial" approach to treatment has been so thorough that we are tempted to believe no one whose goal is peaceful custody has anything to teach us.<sup>2</sup>

There is a basic problem posed for everyone whose work hinges to any extent upon the public temper, and it is this: "How can we best control the effects of an attitude shift so that the change does not run away with itself? How can we dampen the swing of the pendulum so that its arc is not too wide?" The reverse of this question is more often heard. We are accustomed to asking what will happen if we become so concerned with conserving balance that we do not allow new ideas to get established and new techniques to show what they are worth. But now that we have made so many gains in the struggle against mental illness we are probably ready to entertain the question of how to conserve our gains if there is any marked swing in the public mood. Before considering examples of the kinds of swing which can affect our programs we should have

some way of thinking about the extremes to which the pendulum can swing.

It is possible to identify two general styles in which deviance can be handled. It is hard to find 1-word labels for these differing viewpoints—we might call them the firm and the soft approach but the word "soft" is invidious. William James's famous tough-minded versus tender-minded is useful but here the word "tough" carries the wrong flavor. Bertrand Russell uses two terms to describe an ancient and persistent division between philosophic schools—the disciplinarian versus the libertarian<sup>3</sup> and although we cannot use the words precisely as Russell does, they are near enough to represent a pervasive difference between two equally ethical attitudes toward the deviant members of society. Most members of mental health associations, for example, will find themselves identified with the libertarian point of view so we will try to stress the other one, partially to balance the argument but partially because it is probably the viewpoint of that uninvolved majority of lay people whom we call "the public."

#### THE DISCIPLINARIAN

Disciplinarians put the good of the whole group ahead of the good of any individual and hence they treat deviance as a threat to the general good. This means that they focus treatment upon the restoration of group equilibrium. Their approach is on the whole a conserving one rather than an innovating one—they value the past and traditional ways of handling problems. Above all, they value social cohesion. New ideas are examined in terms of whether or not they will undermine the established order, for the disciplinarian places a high value on law, order and predictability. Heroism, courage and nobility are prized

<sup>2</sup> See in this connection, A. Stanton and M. Schwartz, *The Mental Hospital*, Glencoe, Ill., Free Press, 1954, 44-88.

<sup>3</sup> Russell, Bertrand, *A History of Ancient Philosophy*. New York, Simon and Schuster, 1945.



virtues to people with this orientation. The Victorian family is one example of a small subsociety with a fundamentally disciplinarian ethos. Another is revealed in an excerpt from a medical textbook of 1889:<sup>4</sup>

"In most forms of insanity the physician risks very little by positively recommending asylum treatment. He has three important questions to consider: 1st, the safety of the society; 2nd, the physical and financial safety of the family; 3rd, the interests of the patient as an individual. Ordinarily the duty of the physician is in the first place towards the individual patient; in the case of insanity, however, there are many other interests than those of science, and of abstract humanity to the patient, involved. Where we have to choose between endangering the security, health and happiness of healthy and useful members of society on the one hand, and the compliance with sentimental considerations advanced in the favor of decrepit, dangerous or possibly useless ones, we need not hesitate long in our choice."

This orientation is by no means old-fashioned, however. As far as attitudes toward mental illness are concerned, there is reason to believe that the necessity for predictability in social life means that most of the people most of the time do espouse this very attitude toward all deviant behavior, including mental illness. Furthermore, just as the disciplinarian values a cohesive society, a cohesive society is characterized by disciplinarian attitudes. Furthermore, societies become more cohesive when they are faced with a threat from an out-group. Therefore, it is likely that disciplinarian attitudes will prevail when a country feels threatened from the outside. Whatever a realistic appraisal might be, we have had periods of feeling relatively dis-

advantaged in the last few months!<sup>5</sup> There have been many signs in the mass media of a recent re-emergence of the disciplinarian spirit, especially in attitudes toward education and the handling of delinquency, areas in which during the last twenty or thirty years the disciplinarian influence has seemed small. Before analyzing this shift any further, however, let us outline the main characteristics of the opposite point of view.

### THE LIBERTARIAN

The libertarian cherishes the individual above the group and feels that society derives its justification from the happiness of its members. Because he has nurturant attitudes toward deviance he channels his efforts into programs which are aimed at amelioration of the individual's plight. He feels that the group can thrive only as the least of its members thrives with it. Libertarians in general look upon love and co-operation as higher virtues than courage and heroism.

This is the point of view which inspires men to cure the incurable, to help the unhelpable, and above all to redefine the wicked as ill, mistaken or unfortunate. The deviant then becomes by definition a candidate for help in returning to the community as a functioning member. This point of view undoubtedly sustained Dorothea Dix, John Howard and other great humanitarian reformers in their labors. This is the ethos which opens mental hospital doors and installs counselors in prisons; perhaps most significantly it inspires

<sup>4</sup> Spitzka, E. C., *Insanity, Its Classification, Diagnosis, and Treatment*. New York, E. B. Treat, 1889, 397-98.

<sup>5</sup> This paper was first written in late 1957, year of Sputnik.

individuals to band together voluntarily in organizations devoted to the realization of the best available life for everyone.

Now it seems inescapable that all societies must have both of these elements. We all must make some sacrifices for the general good, but at the same time we cannot exist happily without a considerable value upon the individual. Indeed, in a classical study the great French sociologist, Emile Durkheim,<sup>6</sup> showed that suicide rates go up when the constraints that society exerts upon its members become either too great or too few. There is no doubt that we need for harmony both of these points of view. The trouble is that when there is a change—and sometimes only a small one—in the proportion of people subscribing to each side the shift in the underlying feeling can bring a considerable upheaval of the superstructure. We suddenly become aware of all of our old shortcomings and are off to a fresh new start, and the first thing we know we have thrown out the baby with the bathwater.

Our first concrete example of changes in public thinking comes from the field of genetics. During the early part of this century there was a great following for the belief that it was necessary to sterilize the unfit in order to reverse the so-called differential birth rate which was thought to be lowering the national intelligence. The disciplinarian view was in the ascendency; people were alarmed about the ultimate fate of the race. This anxiety had been fed by an inadequate understanding of the new science of genetics and by fear of the ultimate effect of the open-door immigration policy. Frightful tales of the sub-human Jukeses and Kallikaks rang out in

the lecture halls and people became truly alarmed to hear them. For a time it was believed that the biological stock was indeed being rapidly degraded. This belief arose from a confusion between heredity endowment and a number of such factors as poverty, culture and the ability to speak English. Pamphlets exhorted us to work for new immigration laws. A number of popular books advised us how to select marriage partners so as to conserve the best qualities of the race. University graduates were particularly exhorted—apparently with success—to do their bit for the population. Eugenics societies succeeded in arousing the public sufficiently to ensure the passage of sterilization laws in some states.

Now what has happened to all this? Who talks about sterilization of the unfit now? Several things happened: we learned more about the subtleties of population genetics, and the Nazi gas chambers taught us a sobering lesson. However, even before we had these pieces of evidence, and all the time the eugenists were at their zenith, there were minority voices to be heard. Certain religious bodies, as always, opposed sterilization on moral and theological grounds. There were ethical protests, too. Some persistent libertarians were asking why a dull-normal mother who cherished her children should be deprived of her right to motherhood in the interest of the national intelligence level. Others were raising the question, "What is the good of people being so clever when they are often at the same time so cruel and inhuman?" Furthermore, and this is very important, there was another thread of discord. A few voices were raised within the ranks of the geneticists themselves. At the height of the Kallikak family's fame as the most dreadful example of what we were all headed for

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<sup>6</sup> Durkheim, Emile, *Suicide*. Glencoe, Ill., Free Press, 1950.

Lionel Hogben<sup>7</sup> pointed out that the evidence upon which the degraded genetic state of this colorful family rested was extremely unscientific. After sifting it carefully he announced that it proved very little about their natural endowments—the most that could be said for sure about them was that they were very poor and that some of them drank to excess. Nowadays we would say that what they needed was not sterilization but rehabilitation! The most instructive feature of this story seems to be that there were people, probably both libertarians and disciplinarians, who did not make up their minds until they had a satisfactory body of evidence upon which to do so. As a matter of fact, many other voices<sup>8</sup> soon joined Hogben's, and before long the whole edifice had toppled.<sup>9</sup>

#### MODERN EDUCATION

This has been an easy example to analyze and discuss because we have quite a long perspective on it. A somewhat hotter issue is the standard of modern education. In some ways education shares elements with the treatment of the mentally ill. One trains and the other restores members of society to a certain level of conformity, and it is therefore useful to discuss them in the same terms. Some of us have seen in our lifetimes the old grammar school inherited from the nineteenth century go down before the prolonged liberalizing movement of progressive education. We remember the old system in which teachers taught subjects. Later, children had teachers who declared somewhat sanctimoniously that they taught "not subjects, but children." Recently we have been able to say, "This is fine, but surely they must teach them something," without being branded as reactionary.

Suddenly we seem to have reached a

watershed in education. The new trend is toward challenging the child's intellect; there is a shift in focus from the well-adjusted child to the well-educated child. Nobody wants to return to the hickory stick but some people are remembering that while the old grammar school system didn't "take" on all children, when it did it left them thoroughly and permanently educated.

How widely will the pendulum swing in educational methods? It is easy to be swept away with enthusiasm for a new and better system and to say that naturally we will retain the virtues of the softer methods while returning to the tougher curriculum. We may do well to watch closely the way in which the newer approach takes account of exceptional children. The libertarian approach always concerned itself very much with the child in trouble; dull children fared very well—when there were facilities—under this régime. The troubled child, the shy child, the bully, the coward, the nail-biter, the show-off—all of these children were thought to need special care and attention. The success of the system was reflected in how well it coped with its weakest members.

Under a disciplinarian educational system attention turns to the good of the whole

<sup>7</sup> Hogben, L., *The Nature of Living Matter*, New York, Alfred Knopf, 1931.

<sup>8</sup> See, for example, L. C. Dunn and Th. Dobzhansky, *Heredity, Race and Society*, New York, Pelican Books, 1946.

<sup>9</sup> It is interesting that Sweden has for many years had a eugenics program in which sterilization is available to certain parents who request it. The decision has been partly in terms of the public welfare and partly in terms of individual wishes. It has never, apparently, been a *cause celebre*, and it would be interesting to examine, in the light of our own and Germany's experience, why this is so.



group and hence quite logically to special provisions for those who can contribute most to the whole group—the brighter children. Programs to accelerate them and to meet their special needs are suddenly in the limelight. The educational system has a new measuring rod; it is no longer so concerned with remedial work but more with the number of truly well-educated adults it can produce from among its gifted members. While this splendid goal is a great relief to many parents the question of whether the dull and the troubled and the less fortunate will be considered relatively expendable because of this change of emphasis is still unanswered. Will they be left to shift for themselves in the same way that the gifted ones—who are much better able to do it—have until recently had to shift for themselves?<sup>10</sup>

The eugenics movement is history, while the struggle to strike a new orientation in education is very much with us. By the time it is settled there will be new areas of shifting values. Recently, for example, there seem to have been signs of a swing away from the great enthusiasm for psychoanalysis which marked the years immediately after the war. The trend, if it is one at all, is too new to be easily understood, but it would be a pity if a reaction against a certain extreme psychoanalytic orthodoxy

causes us to lose sight of the many creative therapeutic insights it has given us.

It is easy to oversimplify this problem. It would be nice if we could always do the reasonable thing. Or would it? The Greeks in an excess of reason sometimes sat and argued about problems which only action or investigation could solve. At times we seem to need to have causes and to take sides in order to get off the ground at all. The zeal and conviction of Dorothea Dix resulted in such an alleviation of suffering that her example in itself seems sufficient to justify a strongly partisan position. And yet we know that sometimes—as, for example, in periods of extreme zeal for the surgical treatments of mental illness—caution would serve us better.

For lack of a formula for using just the right mixture of reason, enthusiasm and circumspection we will turn now, after posing the general problem of shifting public temper, to a brief consideration of some of the specific precautions against losing the baby with the bathwater that those engaged in the healing arts might take.

## THE CLINICAL SCENE

The general division of the public into disciplinarians and libertarians has a number of specific counterparts, especially in the field of mental health. Greenblatt, York and Brown<sup>11</sup> distinguish in the title of their book between custodial attitudes and therapeutic attitudes. We, in another place,<sup>12</sup> have used a similar distinction, that of traditional versus rational attitudes. If we examine all these dichotomous sets of words we notice that there are pronounced similarities among the more conservative of each pair. The words "traditional," "custodial," "disciplinarian" and "tough-minded" all suggest similar ways of acting. The similarity is not so marked, however, if you look at the more liberal member of

<sup>10</sup> It would be interesting to know whether philosophers of education have a "collection" of schools which have gradually liberalized their methods during the last two decades without abandoning the intellectual rigor of the older grammar schools?

<sup>11</sup> Greenblatt, M., R. York, E. L. Brown, *From Therapeutic to Custodial Care in Mental Hospitals*. New York, Russell Sage Foundation, 1956.

<sup>12</sup> Clancey, I. L. W., J. Cumming and E. Cumming, "Training Psychiatric Nurses—A Re-Evaluation," *Canadian Psychiatric Association Journal*, 2(1, 1957), 26–33.

# Public Attitudes toward Mental Illness

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each pair. The terms "libertarian," "tender-minded," "therapeutic" and "rational" all seem to have one main feature: they are set in antithesis to attitudes which tend to maintain the *status quo* and they therefore contain the common element of innovation.

But the matter is not this simple, for as the number of words we use implies there is more than one style of innovation. Furthermore, there is a possibility that we can combine certain pairs of attitudes which do not ordinarily cluster together; there is, for example, the possibility of a tough-minded libertarianism. Furthermore, although all innovators have probably at one time or another worked very hard for change we have to admit that innovation for its own sake is not always salutary. This was very evident to us recently during the planning of an experiment designed to demonstrate that certain changes in the social milieu of the mental hospital would result in marked improvements in the patients' clinical condition. Four groups of 10 schizophrenic men, none of whom could be severely handicapped or suffering from organic brain damage, were called for in the design. Surprisingly, it transpired that out of the 1,000 male patients in this hospital we could not find 40 men who met this specification. The reason was that some years before a misplaced enthusiasm for a new technique called trans-orbital lobotomy had found favor in this particular hospital and literally hundreds of these operations had been performed. To be fair, there was no evidence that any of these patients were rendered less salvageable by these operations, but it is quite certain that they had not been helped.

There are other examples of innovations made with the best of intentions and in a libertarian mood which we prefer now to forget. Part of the obligation that those

who play professional roles in this process of innovation must assume is that of moving with great care and of making full use of all of the fields of science which are available to us for evaluating what we are doing before we apply our new methods generally. We have a rather conservative medical rule governing us which lays down, as a first principle of treatment, "do no harm" so that we must always temper our innovating impulses with caution.

We are, however, dealing with two sets of variables in this analysis. There are the activities of such innovators as ourselves in our effort to better the care and treatment of the mentally ill, and there is the public attitude with its pendulum swing between disciplinarian and libertarian moods. What effects have these attitudes upon the work of the innovator? When the climate of public opinion favors a more conservative tendency the work of the innovator is undoubtedly harder. He gets fewer grants and less encouragement, and he is often required to demonstrate so thoroughly that his ideas are logical and safe that adequate testing is difficult. On the other hand, when public attitudes are more libertarian the innovator finds a much more sympathetic hearing for his point of view. He finds it easy to raise funds, he is encouraged in his undertaking, and, in fact, at times he is pushed by public sentiment and by legislators into doing things before he is really ready. He is encouraged to apply on a large scale discoveries which may really need retesting and verification. Most importantly, there is a danger of the innovator's becoming confused between the complexities of his own work and the simplicity of the slogans put forward by the lay proponents of change. There is a familiar example in child-raising practices. Many of us have had experience with several types of child-raising; some of us remember ech-

oes of the "children should be seen and not heard" school, and all can probably recall the period of focus upon the dangers of frustrating children. This coincided with a great upswing in a libertarian orientation toward child-raising.<sup>13</sup>

In recent years there has been a new change. We have heard less about the dangers of frustration and more about "setting limits." Children are said to be unhappy if they are allowed complete freedom of expression and to become anxious in ambiguous situations. This has been widely interpreted as a middle-of-the-road policy. It is a rather comfortable, somewhat uncommitted position to take—a middle position for middle-class people—and best of all, it seems to work.

Now it is true that the setting of limits is intermediary between the old authoritarian and the newer permissive methods, and to this extent it is a middle-of-the-road philosophy. But it is not simply a case of the pendulum coming to rest in the center after two extreme swings; it is also a case of the discovery of a new dimension of

behavior.<sup>14</sup> The newness consists in the idea of "limits" implying that the social situation is going to be a continuing interpersonal relationship which will concern itself in part with the idea of freedom and of limits to freedom. Finally, the idea of "limits" implies that there needs to be a lack of ambiguity about our social lives because ambiguity is anxiety-provoking, and this is a new idea. In short, the concept of person-in-the-situation<sup>15</sup> has been added to the older dimension of the inner development of the child. The idea of limit-setting involves a more complex idea than that of simple compromise between extremes.

This concept of person-in-the-situation has been extremely important in the newer milieu therapies which we have employed so successfully with the mentally ill. In most state hospitals for many years patients used to be thought to be of two kinds—good patients who were docile and bad patients who were rebellious. In the traditional hospital docility was rewarded with a narrow range of privileges and rebelliousness was rigorously controlled and sometimes even anticipated before it appeared because it was thought so important to control it. There is a scarcely credible example<sup>16</sup> in a mental hospital where for some reason it had been decided that the patients diagnosed as hebephrenic were a potentially dangerous and rebellious group. As a consequence of this belief, particular care was given to the handling of hebephrenics.<sup>17</sup> They were kept together on one ward and every day they were taken together to a walled exercise court. Because it was thought that they were potentially disturbed, they were not allowed to move around freely but were distributed on benches around the court. If a patient tried to get up, this was taken as evidence that he might be becoming disturbed. As the attendants had been taught that if one per-

<sup>13</sup> An example of the extent of this strongly held libertarian belief among the laity is given and discussed in the authors' *Closed Ranks*, cited above.

<sup>14</sup> For a lucid and dramatic comment on the vital difference between "the swing of the pendulum and the motion of growth," see Lionel Trilling's *The Middle of the Journey*. New York, Viking Press, 1947, 299-300.

<sup>15</sup> For early statements on the importance of this concept, see Lois Murphy's *Social Behavior and Child Personality* (New York, Columbia University Press, 1937) and H. S. Sullivan, *Conceptions of Modern Psychiatry* (Washington, D. C., William Alanson White Foundation, 1945).

<sup>16</sup> This story was related by D. I. L. W. Clancey, who uses it as an example of Robert Merton's principle of the self-fulfilling prophecy.

<sup>17</sup> A group of psychotics not generally considered aggressive.



## Public Attitudes toward Mental Illness

CUMMING AND CUMMING

son became disturbed others might quickly follow, any patient showing signs of wishing to move out of his place on the bench was restrained immediately by several attendants. If he then became frightened and in his fear tried to fend them off, he was quickly subdued and returned to his place in the circle. By such quick action was disaster averted, and each time this happened a mistaken belief was reinforced.

In many hospitals for many years practically all effort was spent in preventing trouble before it occurred. This resulted in patients' living in environments which were often highly ambiguous, in which demands must often have seemed contradictory. In such an environment attendants did not define the patients as legitimate objects for personal relationships, patients were discouraged from having personal relationships with one another, and there was only the most impoverished, fragmented, rudimentary social structure. It is easier now to see how patients became desocialized and how chronicity set in, because we now understand the new dimension of patient-in-the-situation.

A few hospitals have faced the problem of the years of chronicity which they have inherited with great courage and intelligence. It is not an easy task to change a hospital of this sort, because the whole administrative structure has gradually come to be in accord with the old system. This may have to be changed—and changed against resistance—before a new system can be brought into effect. Anyone who knows the traditional mental hospital knows the profound feeling of inertia which permeates it. On the wards the people who have been trained to consider one set of actions right and proper have to be convinced first of all that new ways of doing things are possible; then they have to feel that it is worth while trying to change, and finally

they must believe that they will be rewarded for changing. Once they decide this, they have to go through the difficult process of learning new ways of interacting with patients. They must be given leadership in establishing a new social structure around the patient groups. To do these things is incredibly hard, time-consuming and often frustrating, but it is very rewarding. When it is done—and it has been done in a large number of places—there are dramatic changes; the stillness leaves the chronic wards as the patients become social individuals again, as they begin to accept social responsibilities, and as they become more cooperative and sociable. Out of these changes come such innovations as patient government, the open-door policy, and the use of volunteers. Finally, when all of this work and effort has gone on, there is public acclaim for the progress. If the story is written up in the press more than likely its central theme will be the amazing fact that mentally ill people can be kept in hospitals without straight-jackets or other restraints, and with the ward doors unlocked. The open door will have become a symbol for the change as the phrase middle-of-the-road has become the symbol for a fundamentally new approach to child-training.

But there is a problem in this development of a symbol.

Perhaps the most famous example of the open hospital is that of Dr. T. P. Rees at Warlingham Park in England. It is said that it took Rees seven years of diligent work among his staff to develop his treatment policies to the place where he wanted them to be. At the end of this time the success of the treatment must have made the open hospital merely a logical extension of all that had gone on before. But Warlingham Park is *not* famous for being a hospital with very high standards of treat-

ment; it is famous because none of its doors are locked.

Thus we can see how a complex process involving constant therapeutic effort and the continuous use of rational scientific theory has been assimilated entirely to the humanistic libertarian approach because of the symbol assigned to it. This is *not* to say that it is *not* a humanistic program. It most certainly is. Indeed, it is humanism at its best since it combines the libertarian tenderness toward the individual's suffering with intelligence, persistence and courage—courage which is a high disciplinary virtue. But it is something else as well, and it should not be given a monolithic label which may endanger it when public sentiment changes.

You may feel that we have been placing undue emphasis upon this point. After all, in recent years we have had a libertarian climate and it is natural that the symbol of progress should be a libertarian one; it is even advantageous to have it so. Our concern is, however, that the great complexity of the problems that we deal with should not be lost or obscured by the use of slogans. In this particular issue, whether the doors are open or whether they are locked can become a moral issue and doctors and hospitals can be judged as good or bad depending upon whether or not they subscribe to this particular policy. Just as once it was possible to keep patients herded within a dayroom and trained not to cross the doorway leading to the hall even when they were unattended, so it is quite possible that we can have open doors without an accompanying therapeutic program. Such a practice, which is perfectly possible, could make a mockery of our intentions. If there is continuing emphasis on the symbols only we can expect to see

hospitals complying with public demands and giving them only the window dressing. This could result in the discrediting of the programs for which these symbols have come to stand. Then if the pendulum swings and the public mood changes we shall have difficulty not only in defending our symbols but in defending the programs they represent. Crusades must always, of course, have flags, and causes will always generate slogans, but this is no excuse for our becoming confused. It is important that the mentally ill be treated humanely. It is just as important that they be helped to get well. We must not let the success of new methods blind us to why they work.

One last example of what we mean will be sufficient. A few years ago a program for regressed patients on the poorer wards of a large hospital was being developed. The program was carried out in groups from 8 to 10 patients in which strong group identity was encouraged and in which group processes were utilized as therapeutic tools. As individual patients improved, doctors and ward supervisors were delighted. They felt that as soon as a patient had recovered to the place where he could function efficiently on a better ward, he should be moved to such a ward. One of us, the planner,<sup>18</sup> opposed this view because we knew that breaking up the groups would destroy the very therapeutic process which we had put into effect. We felt it wiser to hold the groups intact until the patients had improved to the place where they could all be moved together to better surroundings. There was, at the time, some criticism of the heartlessness of our approach. But this was not really the point. Neither we nor the critics were heartless; we simply had different degrees of sophistication about the means to the end we both held, namely, the recovery of the patient. And the reason we did not agree was because the planner

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<sup>18</sup> John Cumming.

was focused upon the dynamics of social recovery in the group situation and the others were focused upon the traditional symbol of individual improvement, that is, removal to a better ward.

The point, in summary, is this: *we must know what we are doing as well as why we are doing it.* We can, by being rational and analytical in our mental habits as well as humanitarian and libertarian in our moral posture, establish our work on such firm foundations that if public attitudes swing to a more disciplinarian mood our policies and methods of treatment will remain acceptable. They will be acceptable

not only because they are humanitarian but because they work and therefore serve both society and the individual best by being the most efficient means of dealing with the social problem of deviance as well as the individual tragedy of illness. If we are to achieve our ends we must combine not only the libertarian ideal of humanism and the disciplinarian ideal of courage, but we must add to these a thoughtful rational habit so that our work will be valuable no matter what the temper of public opinion. In this way we shall not lose—as we must not lose—the tremendous advances we have made in the last few years.



# Research in mental health

## Results obtained and plans for the future

On November 8 and 9, 1958 the committee in charge of the research program sponsored by the Supreme Council of the Scottish Rite in cooperation with the National Association for Mental Health held its annual meeting at which chief scientists of research projects in this program reported on the results of their work during the last year and on their plans for future investigations. This is a biennial event which was started some years ago. Its purpose is two-fold: First, to provide the committee with information that can be used in evaluating the progress of the projects; secondly,

and more important, to give all the research workers an opportunity to learn what the others are doing in their special fields. In this way each is enabled to see how his particular work fits into the general program and how he could apply some of the methods used by the other scientists to his own project, and thus broaden the scope of his investigations.

In most respects this meeting was similar to the ones held previously, but this year there were two significant new developments:

- The title of the program was changed from research in dementia praecox to research in schizophrenia.

- During this last year plans were formulated for the organization of a comprehensive program of research in the general

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Dr. Malamud is directing the expansion of the research program carried on by the National Association for Mental Health. This paper is based on a report he presented November 19, 1958 in Kansas City, Mo., at the organization's 8th annual meeting.

field of mental health to be supported by the National Association for Mental Health in addition to its participation in the sponsorship of the more specific program of basic research in schizophrenia.

These two developments are so intimately related to one another and to the progress of research in this field that it seemed most appropriate to use them as the pivotal point in this article.

### THE CHANGE IN TITLE

At its last executive meeting, the Scottish Rite committee, after due deliberation, decided to change the title of the program which it sponsored from research in *dementia praecox* to research in schizophrenia. True, usually a change in name does not necessarily imply an important change in content. In this case, however, the change was highly significant. The term, *dementia praecox*, under which this disease was first described 100 years ago, literally meant "mental deterioration (dementia) such as is observed in cases of advanced senility, but occurring in adolescents or very young adults; in other words, at an unripe age (*praecox*)."

This precocious deterioration, furthermore, was considered by Morel, who first described this disease as due primarily to a pathological heredity, as an inevitable fate which these unfortunates brought into the world with them from their ancestral background. Burdened by this inheritance and doomed to an incurable disease, these persons, as he saw them, were left without any hope for prevention before the disease became manifest and nothing one could do to treat the illness after its beginning. This hopeless attitude towards the disease, which was soon found to be highly frequent in increasing numbers of young people, continued for many years and obviously stifled any attempts to search for its causes and

thus to develop methods of prevention and treatment.

The name, schizophrenia, however, was proposed by Bleuler to indicate, as the term implies, a "splitting of the mind or personality." It differed from the old connotation by introducing the idea of a disease process which developed during the lifetime of the afflicted individual and which largely depended upon injurious experiences to which he had been exposed. It meant that although certain vulnerabilities to stressful experiences may be inherited, a person who had these vulnerabilities would not of necessity develop the disease, but would become a victim only if a large number of injurious events took place during his life. Furthermore, the new term implied that the outcome was not an inevitable deterioration, but that, if the effects of these experiences could be counteracted by suitable methods of treatment, one would be justified in expecting improvement or recovery. In other words, introduction of the new name and, what is more important, the idea behind it, brought with them the hope for possibilities of both prevention before the onset of the disease and treatment once it started.

It is true that 50 years ago when the new name *schizophrenia* was first introduced, it was based mostly on theoretical considerations with very little valid scientific proof available to support it. This was true even 25 years later when the Supreme Council of the Scottish Rite initiated the program of research in this illness. Most probably because of this (although the name *schizophrenia* already existed at that time), the committee still maintained the name of *dementia praecox*, presumably until such time as its research work brought results which could provide a solid foundation for considering this a disease process produced

by causes similar to those of other diseases and therefore subject to the same type of basic research as any other medical disease.

This long-term realistic attitude also expressed itself in the nature of the research that the Supreme Council, on the advice of its committee, undertook to sponsor. It was not a search for a quick remedy, but a slow and systematic study of the basic biological, social and psychological sciences of human behavior which would lead us to a better understanding of the disease and a rational formulation of how to deal with it. Actually, it was not until very recently that we began to see the importance of the discoveries made in this research work and the possibility of gaining an insight into the nature of the disease and the manner in which it can be combatted. Thus it was only this last year that the committee felt justified to substitute the name *schizophrenia* for *dementia praecox*.

During the period covered by the reports presented at the meeting last November, 26 projects were supported, each dealing with original research in various basic sciences of human behavior. They include studies in biochemistry, physiology, endocrinology, genetics, neuropathology, psychology and sociology. In addition to supporting original research of this type conducted by scientists of national and international reputation in their particular fields, funds were allocated for eight stipends to support young students who have shown interest in and aptitude for research of this type, for the purpose of training them as future workers in this field. Many of these projects have been carried on for years. Others have just recently been started. Each of them covers its own technical field in such a comprehensive way that it would be both impossible and not particularly desirable here to go into their technical details. It would be well, however, to describe briefly some

of the studies, particularly those which demonstrate with special clarity that we are dealing with a disease process rather than an hereditary curse, and that with a more adequate knowledge of its causes and manner of development we will be able to devise better treatment and a systematic program of prevention.

One of the research areas which has been particularly indicative of the active, process-like nature of schizophrenia and which has brought especially promising results within the last few years is the biochemical changes occurring in this disease. As an example of this we have in the Illinois Neuropsychiatric Institute a project which deals with derivatives of chemical substances produced in human beings which, given in large quantities to animals, produce marked pathological changes in their behavior. Furthermore, it has been reported by other workers that these derivatives, given to normal individuals for brief periods of time, produce temporary mental changes resembling schizophrenia. This experimental production of "models" or "imitations" of mental disease has been successfully achieved in the past through the use of a number of drugs derived from plants. Now, however, the fact that more or less similar effects can be produced by substances found in the body brings up the possibility that the production of abnormally large quantities of these substances in human beings in certain stress situations may be associated with the development of mental disease.

The same research workers have also found that certain drugs, which they have produced synthetically, are effective in counteracting some symptoms of mental disease and of preventing the development of these symptoms if used before the administration of the toxic substances. This, of course, introduces important implications for the fu-



ture, in that a more adequate knowledge of the factors involved in the development of the disease may enable us to devise rational methods for treating the symptoms and preventing the disease.

A number of our research workers in other institutions are actively studying other aspects of this particular subject. In a large measure their findings lead to the same conclusions, with the added advantage of checking up on possible errors and with the assurance that the variety of methods used will make it possible to reach more reliable results than if it were done in only one laboratory.

Another group of projects which demonstrates particularly well the transition from the concept of a pathological state to that of an active process are those investigating the genetic-dynamic aspects of the disease. It is quite true that people who develop schizophrenia are most likely to have some constitutional weakness rendering them more vulnerable to certain types of injurious experiences than the average person would be. This being the case, it is most essential to find out, first of all, the nature of this weakness and whether it is due to some deficiency which could be compensated for, and secondly, to identify the experiences which are particularly likely to harm those endowed with such a vulnerability. During the last year our research workers have reported results which indicate that this constitutional vulnerability may be dependent upon a specific disturbance in the bodily defense mechanisms as they are represented in a variety of cellular protective functions. The study of this disturbance is now being carried forward very intensively by Dr. Kallmann. It is obvious that a positive identification of such a disturbance could serve as the basis for the development of a systematic preventive program. At the same time, our child psy-

chiatrists and psychologists have been working very actively on identifying the nature of the experiences which are particularly likely to lead to the development of schizophrenia in vulnerable individuals. A number of important publications have come out from several institutions, particularly the Putnam Children's Center and the Judge Baker Guidance Center, indicating the nature of these injurious experiences and the manner in which an understanding of them can be put to use in the treatment of children who have developed schizophrenia and in the organization of preventive measures.

Closely related results have been reported by Dr. Whitehorn's group of research workers who undertook a series of studies on psychotherapeutic methods of treating these patients. They found that the treatment's efficacy depended largely on the type of relationship between the physician and the patient, as well as the particular steps that were employed in setting up this relation. In addition to this, these studies have further clarified the nature of the illness and the social and psychological factors that are in a large part responsible for its development.

A particularly important contribution to the understanding of the relationship between clinically and psychologically observed behavior abnormalities and relevant biochemical disturbances has been reported by research workers in one of the projects at the Lafayette Clinic in Detroit. They take their point of departure from the generally accepted fact that one of the most striking clinical observations in schizophrenia is the apparently lowered availability and mobilization of outwardly directed energy, particularly in response to stress. The patient seems either unable or unwilling to exert himself physically or emotionally to react adequately to stress situations as a

healthy person would. Figuratively speaking, he adopts a sort of "couldn't care less" attitude. At the same time it has also been found experimentally that the amount of energy available to a normal person and his readiness to mobilize it in response to stress is very closely tied up with the various stages of phosphorous metabolism. With this in mind, the researchers proceeded to compare the stages of phosphorous metabolism in schizophrenic patients with those of healthy persons when both were at rest and also when they were placed under identical types of stress situations. The results were clear: in response to stress the healthy person invariably showed a marked increase in phosphorous activity, whereas in the chronic schizophrenic there was no change or even a marked decrease.

"These findings," the scientists conclude, "suggest that in schizophrenia there is a basic disturbance in this energy supply. This disturbance appears to involve first a use of large amounts of energy in the chronic schizophrenic patient in a different manner than normal, and second a failure in the ability to apply energy effectively when needed. . . . It suggests the presence either of a substance which blocks the use of energy or an enzyme defect which prevents the normal flexibility in energy utilization."

A number of other studies—physiological, neuropathological, social and cultural—have helped in furthering our understanding of the particular types of disturbances that are produced both physically and psychologically in these patients, so that our ability to recognize or diagnose these cases at the earliest possible moment has been enhanced. At the same time we are also making progress, on the basis of such studies, in the effectiveness with which we can predict the eventual course of the illness. At the outset of this program 25 years ago,

when all of the research was devoted primarily to the basic sciences, it may have seemed to many that there was very little relationship between the projects investigated and the disease, *dementia praecox*. As time went on it became quite obvious that with the coordination provided by the committee and the progress made by each investigator there had developed a gradual convergence of the program towards the common goal of trying to understand the disease in order to find reliable means of combatting it. The nearer we approached that stage the more important it became to consider very seriously two other activities that should be closely associated with a research program of this type. These were:

- As we continued to make progress in basic research, the technical knowledge necessary to study adequately each one of these basic sciences increased in scope and complexity. It became very important, therefore, to train scientists who would be adequately prepared for and genuinely interested in this subject, so as to carry on research of this type in the future. This meant that to strengthen our program while still continuing to support research by highly qualified original workers, we must recruit younger people who could become proficient in the specialized techniques provided by the more mature scientists and who could continue their investigations. Recognizing that need, the committee has developed a program of training students (mostly during the course of their medical studies) by offering them modest stipends for their summer vacations so that they will be in a position to utilize this time to work in the laboratories of some of our original research workers, get to understand the methods used in such work, and become interested in this area of research. At present eight stipends are being allocated to



students selected by prominent scientists in universities or medical schools, and we are looking towards an increase in this program so that as we extend our work we will also have a greater number of well-qualified persons to do it.

● At the same time it has become obvious that our research workers in the basic sciences are able to contribute more knowledge of the fundamental factors in the causation of this disease and that the possibility of applying this knowledge in a practical search for adequate methods of treatment has become more real. Thus it also became essential to enlist the aid of other workers or agencies who could be both willing and able to undertake the evaluation of the practical application of these results—whose research would lead to improved diagnostic and treatment methods, to the application of principles discovered by the research workers to public education, and to the improvement of conditions under which the adjustment of people who have been mentally sick or who are susceptible to mental illness can be maintained at an adequate level. Similar needs emerged for the establishment of programs of readjustment or rehabilitation of those patients who have been treated but in whom some defect may have been left by the disease which prevents them from returning to their previous manner of living.

It is fortunate indeed that the original organization of this program was implemented by the Supreme Council of the Scottish Rite in close cooperation with and with the professional guidance of what was then known as the National Committee for Mental Hygiene, one of the predecessors of the National Association for Mental Health. The latter, like its predecessors, has continued to maintain as one of its

main goals the practical application of this type of knowledge gained through research in the basic sciences. It is therefore very gratifying to find that during the last year the National Association for Mental Health has decided to establish a research program which, while reaching out for a broader scope of problems to be investigated, will complement and supplement the one sponsored by the Scottish Rite. This is obviously a natural sequence to the cooperation between these two agencies over these many years. It will make it possible to utilize all of the work that has been done in the past and that will be continued in the future by the research workers in the Scottish Rite program in dealing with the more comprehensive activities of the NAMH.

To assure adequate cooperation and mutual help in carrying on both of these programs it was agreed by both agencies that the research director of the Scottish Rite program will also be the director of the NAMH research department. It was understood, however, that the Scottish Rite program of basic research in schizophrenia will maintain its independent and unique role as it has during the 25 years of its existence; that it will continue the pioneering exploration of the fundamentals of the nature and causes of this illness; that the committee on schizophrenia will maintain its present composition and functions specifically devoted to this program; and that the director of research will continue to devote the same amount of time and effort to the coordination and direction of this program as he has until now. Insofar as the program of the National Association for Mental Health is concerned, the research director will devote to it the time he has hitherto given to teaching, clinical and research activities as chairman of the division of psychiatry at Boston University's medical school.



The NAMH research committee consists of some of the most prominent representatives of the broad spectrum of scientific and professional disciplines relevant to the field of mental health. They have the skill and judgment essential in the practical administration of such a program. This committee will be responsible for evaluating and selecting the projects and programs to be supported, establishing policies for the research department and advising and guiding the director and his staff.

The formulation of a well-defined and systematic program will be undertaken by the research committee as one of its first functions. The general outline of the fundamental principles of the program, however, as it was presented originally to the board of directors of the National Association for Mental Health and discussed with some of the members of the committee in a preliminary way can be described as follows:

A major function of the program will be the adequate support of scientific investigations of all areas relevant to the fight against mental illness and the promotion of mental health. This support should consist not only of necessary financial help but also of essential information and technical advice whenever requested by the applicants. The scope and nature of the research to be supported, in keeping with the general objectives of the program of the National Association for Mental Health, will include all the phases of human behavior and adjustment in health and illness. In this regard we are especially fortunate in that the inauguration of this work will have as a background the pioneer work that has been carried on for 25 years and will be continued by the Scottish Rite program. True, this work concentrated primarily on basic research in schizophrenia, but this disease occupies a unique position

in the field of mental illness. It is not only the most prevalent of these illnesses, but it affects human beings in such a comprehensive fashion that anything we learn about the nature and causes of schizophrenia can be used in studying all other personality disturbances. The results reported above, therefore, can serve as an excellent starting point in the broader program we are now entering. It is also important to emphasize that although we are planning to continue active support of investigations in the basic sciences we will also encourage and assist those who are engaged in fact-finding and epidemiological studies and investigations dealing with the application of the results of basic research to the practical phases of treatment, prevention and rehabilitation.

As the potentialities and needs for expanding the investigations develop both in scope and complexity, they bring with them a progressively increasing need for personnel. This means that along with supporting research in progress we will also have to concentrate on recruiting and training persons who will be well-qualified to join in this work and continue it in the future.

As we survey the present status of research in mental health throughout the country we find that to get a true picture of both needs and potentialities it is necessary to go beyond published material or reports presented at meetings. Very frequently we find, in institutions for the mentally ill or in community clinics, highly promising prospects and valuable material that have not been utilized. Sometimes this is due to exaggerated modesty or lack of suitable contacts for persons who have the potentialities for research; in other places it may be the result of poor facilities for such work. At the same time it is important to realize that such a program as we propose to establish, if it is to result in

fundamental knowledge that transcends regional and cultural superimpositions, will have to represent a wide variety of local characteristics, both as to particular needs and as to specific ways in which problems must be handled. Because of this it is proposed that this program should not limit itself to the support of research entirely on the basis of incoming applications, but that we should also go out and search for possibilities, stimulating, encouraging or acting as consultants wherever this is desired or actually sought for by local workers.

It is quite obvious that a program of this type, carried out within the framework of the general plans of the National Associa-

tion for Mental Health, can succeed only if it is given the wholehearted support of the entire membership and all the state and local mental health associations. This is necessary not only because they are the source of financial support, but because universal representation of all parts of the country will definitely assure validity of results and the highest success in applying them to practical needs. Given such support and the high quality of scientific competence represented by the committee, I have no doubt that this program will assume the position of leadership in mental health research that rightfully belongs to this association.

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PETER E. SIFNEOS, M.D.

# Preventive psychiatric work with mothers

Ordinary people do not usually visit a psychiatrist. If they have emotional problems they hesitate to communicate them even to their close friends and try to deal with them on their own. Access, therefore, to such individuals and assessment of their emotional problems is difficult. On the other hand, one is usually impressed by statements of emotionally disturbed individuals about the times when they felt well. They invariably refer to missed opportunities to solve past emotional problems, or to lack of knowledge about whom they could have turned to at such times. They also acknowledge that psychiatric help

might have prevented their present difficulty.

An attempt to describe preventive psychiatric work with emotionally stable young mothers who had a disturbed relationship with one of their children will be briefly discussed in this paper.

Over a period of two years 50 young mothers came to the Human Relations Service of Wellesley, Mass., a community mental health agency in a Boston suburb, to talk about the emotional problems of one of their children. Usually aggressive or excessively docile behavior of the child at school or in the home constituted the majority of these problems.

The mothers came to the agency on their own or were referred by their family physician, their minister or a school teacher. School teachers referred 17, physicians 7,

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Dr. Sifneos directs the psychiatric clinic at Massachusetts General Hospital and is an associate in the department of psychiatry of Harvard Medical School.



ministers 3 and the rest came on their own initiative.

When first seen by the psychiatrist most of the mothers appeared to be somewhat anxious and tense; others felt guilty. They said they knew something was wrong and they sensed that in some way they were involved in their children's difficulties. A few denied any knowledge of difficulty at first, but by the end of the interview it had become apparent to them also that they were connected with the problems of their children. They were therefore willing to return for a second interview. It was usually quite apparent that the mother-child relationship was disturbed and that the mother or the child or both of them needed some help.

In some cases the disturbed behavior of the child generated anxiety and guilt in the mother, as well as indecision. A change or deterioration in her relation with the child and continuation of his disturbed behavior, either at home or in the school, led to a progressive inability to cope with the child's emotional problem. Being unable to deal with this situation and trying to punish the child increased the mother's anxiety. This in turn further aggravated the disturbed behavior of the child. It was soon obvious that a vicious circle was formed that radiated distress to the whole family. The talk with the minister, physician or teacher and referral of the child and his mother to a community mental health agency intensified further the mother's awareness of her emotional difficulties. It was because of these feelings that the mothers were easily motivated to work with the psychiatrist.

Three approaches were usually considered after the mother and the child had been interviewed by an adult and a child psychiatrist respectively. First, if it appeared that the child and the mother were severely

disturbed they were both referred for psychiatric treatment. This occurred on only one occasion. Second, in two cases the child treated by a child psychiatrist and the mother was seen by a social worker. Third, with all the 47 remaining mothers it was thought that the disturbance or emotional problem of the child was mild, but that it had the potentiality of becoming serious if the mother was not seen briefly by the adult psychiatrist for guidance. An attempt was therefore made to intervene to prevent future complications.

Most of the mothers were young, ranging in age from the middle twenties to the late thirties. They were intelligent, cooperative women without overt psychiatric symptoms or serious character disorders. They were essentially healthy "normal" women.

A systematic attempt was made in subsequent interviews to help each mother understand some of the underlying emotional conflicts in her child and quickly motivate her to view her own actions as possibly contributing to his disturbed behavior. This was in most situations achieved quickly—that is, in four or five interviews spaced over a few weeks to not longer than three months. During this time the child was observed closely by the teacher at school or by his family physician. They both communicated occasionally with the mother's psychiatrist. In some cases the child was directly observed by the psychiatrist in the school setting.

Usually in a short time there was a change for the better in the child's behavior. It was observable by the teacher and the mother as well as by the other members of the immediate family. The most striking change occurred in kindergarten, first grade children or young adolescents. Out of the 50 children involved, 14 were in the age group 5-6 and 15 in the age group 12-14, a total of 29. Disturbances and problems

in these two critical periods in a child's emotional development turned out to be the most common hazardous situations faced by the mothers who came to the community mental health agency.

The following cases are illustrative:

The mother of a 6-year-old boy was referred to the mental health agency by his teacher because of "unusually docile behavior at school," withdrawal from other children, tenseness and constant biting of his fingernails; in direct contrast was his behavior at home, where he was aggressive both against his mother and his siblings. The boy was the oldest of three children. He had essentially a normal development. There were no feeding problems. He walked and talked normally and was toilet-trained by the end of the 18th month. He did not seem to be disturbed by the birth of his siblings. He was in good physical health.

According to the mother, he became very dependent on her when he was 5 years old and began reacting with unusual fury when she would not give in to his demands. She emphasized that she had always had a strong desire to be "independent" and added, "I also teach my children to be independent." Both she and her husband had put pressure on the oldest boy to do good work at school. He worked hard and they praised him, but his ferocity when his demands were not satisfied by his mother seemed to continue unabated. The boy spoke often about violent deaths and on one occasion he hit one of his brothers on the head, causing some bleeding. On that occasion he was punished severely by his mother, and following this he had a temper tantrum.

The boy was interviewed by the child psychiatrist, who felt that although appearing somewhat shy he seemed to be a fairly normal child with no serious emotional

disturbance. He was also observed by the psychiatrist on two occasions at school. There he did not partake in the discussion and did not communicate with the other children during the study hour. When asked questions, however, he always came out with the correct answer and seemed to be interested and alert during the times when the teacher paid attention to him. During recess he would run, or rather gallop, aimlessly alone all over the playground until, finally exhausted, he would sit down by himself.

The father was also interviewed at the agency. He drew essentially the same picture of the boy as the mother had done, and emphasized that his wife had great expectations for their son and pushed him intensively to achieve success.

The mother was 31 years old. She too was the oldest of four girls. Her father, an excessive drinker, was unable to support the family, and her mother had had to work. At a very early age the mother was given the responsibility of running the household and bringing up her sisters. She resented these responsibilities bitterly but, a perfectionist, she met them well. Willing and capable, she could not go to college. After she had married young and "successfully," she ran her family, including her husband, with an iron hand.

She was seen six times over a period of three months. The main focus of the interviews was the "problem of her son."

At first she was hesitant to give information about herself: "After all, I came here to talk about my son's problems." She soon relaxed, however, and discussed her life fully and easily. She described her anger against her father, and her subsequent guilt, with much emotion. She also talked about her mixed feelings for her mother. When she realized she was treat-

ing her son in the manner her parents had treated her—a manner she had thought very unfair—she became less demanding of him. Having talked freely about her hostile feelings for her sisters, she was able to realize her oldest son might have hidden hostility and jealousy for his own younger siblings. She could see how by being negativistic towards her when she failed to gratify his wishes he was expressing his need for rebellion. She quickly became more understanding. She gave the boy special privileges as "the oldest child," and a "special time" was also allocated to him to be with his mother. She did this without hesitation. As time went by her anxiety subsided. She was more tolerant of her son and more at ease with him. After she visited her own parents for the first time in six years she announced with pride that she felt little tension with them, something that had never happened to her before. The boy responded to this change in his mother very rapidly. His aggressive behavior at home practically disappeared, and he became more cooperative. He again started to play with his siblings and with other boys in the neighborhood without getting into fights. At school he was less tense, less withdrawn.

As the mother became more self-confident she began talking about how much she enjoyed her son's improved behavior, and added that "now I am able to understand his problems."

In three months a report from the school teacher stated that the boy had had a transformation: "He was much more relaxed, he played with the other children, and he did not bite his fingernails." The father also reported "good behavior" on the part of his son. It was decided then that the interviews with the mother should end. She seemed to be happy and felt that she

had more insight into her own problems and into her son's difficulty.

A 5-year-old boy and his mother were referred to the mental health agency by the pediatrician because of the boy's fear of being injured. The child psychiatrist who saw the boy decided that no therapy was necessary at the time but thought that he should be seen occasionally, because it was possible that if his phobia did not clear up he might require treatment in the future.

The mother was seen six times over a period of two months. She gave the following history: This was her first child. She had been unhappy about her pregnancy and had had a difficult delivery. The baby had had no feeding problems. He had walked and talked normally, and was toilet-trained by the age of two and a half years. He had had the usual childhood diseases and had developed quite normally up to about six months before her referral to the agency. At that time, while playing on the beach, he saw a friend of his who had broken his leg and was wearing a cast. He seemed to be unusually interested in his friend's misfortune. He was told by his mother "when one misbehaves sometimes one falls down and breaks one's leg." He seemed to pay little attention to this statement. Five months later, while he was playing in the yard, the ball that he was playing with rolled outside the fence. As he ran to catch it a car sped by. His mother, who was running after him, was very upset and gave him a "spanking." She told him that he should be careful because the car could have "cut off his leg." Following this the boy became very upset, was unable to sleep, had occasional nightmares, and asked for constant reassurance from his mother about losing his leg or being injured. The mother grew alarmed and took him to



their pediatrician, who referred them both to the mental health agency.

The mother was 35 years old. An only child, she had been brought up by two rigid parents who had been divorced when she was 12. From then on she lived with her father, whom she described as very "sadistic" and who when under the influence of alcohol enjoyed taking her clothes off or slapping her repeatedly on the face. After she was graduated from high school she worked as a secretary for 12 years under a very "strong man." She met her husband, a somewhat passive individual, and married him. She was dissatisfied with married life. She always had ambitions of going back to work. Unhappy as a housewife, she tried to adjust by taking meticulous care of her son and her household. She admitted being at times very angry and domineering with her son.

In the interview she related fairly well but had a tendency to try to dominate the interviewer. She was quite intelligent and was willing to question the role she had played in precipitating her son's phobia. When it was explained to her that at some period of emotional development boys seem to become quite attached to their mothers she showed interest and mentioned that her son had been quite attached to her over the last year. She said that on occasions she had been quite embarrassed by his affectionate caresses and realized that her threats of punishment were due in part to her own uneasiness about this. She thought she might have been a little too harsh with the boy. She soon was able to see that her hostility and resentment of her father's domination had something to do with her trying to dominate her own husband and child. In the third interview she reported she had tried to be more lenient and had stopped her threats, and

seemed to respond to her son's playfulness by being more relaxed.

In the last interview, two months later, she reported that the boy had not had any disturbing dreams, had stopped complaining about his phobic symptoms and now did not seek constant reassurance. She said she was encouraged. One year later, when her son was in the first grade, she reported he seemed to be quite relaxed and had made friends at school. His phobias had not returned. She was pleased with his progress and felt she had contributed to it.

A 50-year-old mother was referred by her minister because she was somewhat depressed and very tense over the overt rebellion of her 14-year-old daughter. The daughter had repeatedly defied her mother and had announced to her in the middle of the school year that she was leaving school and was going to stay home and do whatever she pleased. The more the mother pleaded with her the more defiant the girl became. It was quite obvious that in their past relationship the mother had been quite ineffectual in her discipline over the years. Despite having made attempts in the past to "draw the line" she had been unsuccessful. She said that her husband was of no help to her and that their relationship was poor. He had always taken her daughter's part in the past arguments. When the girl had announced that she was going to stop going to school, her husband had laughed and turning to her had said, "Now what are you going to do about this?" At the same time she related that otherwise she and her daughter had a good relationship and that difficulties had resulted only when she attempted unsuccessfully to discipline or punish her.

The mother was seen on five occasions over a period of three months, and an at-

tempt was made to give her some insight into her present involvement with her daughter. It was pointed out that the girl's defiance and rebellion were part of the adolescent's need for independence, and that the more the mother was involved with it the greater her chances of failing. She decided to pay little attention to her daughter and allow her to do whatever she pleased. She announced this both to her husband and to the girl, but for some time it was difficult for her to carry it through and to disengage herself from her involvement in her daughter's problem. For example, when her daughter went off to study and hinted that she might return to school, the mother became very pleased and encouraged her to do so. As time passed, however, nothing seemed to happen. It was pointed out to the mother that although it was understandable that she would wish for her daughter's return to school the quickest way to achieve this would be by helping the girl realize her mother had meant what she said when she announced she would not be involved in that situation.

She finally managed to make herself stand on the sidelines and watch what developed. It was soon apparent that her daughter had become tired of her lonely existence in the house, and she announced she might try to go back to school temporarily. Her mother made no comment. After the girl returned to school, realized she had missed much valuable time and was faced with the possibility of having to repeat the same grade, she became alarmed and rushed to her mother for forgiveness and help in making up her lessons. The mother returned to the agency and announced she was delighted by this turn of events. She said she declined the request to help the girl with her studies. She added that she now understood adolescent behavior a little

better. She also said she had learned something about "drawing the lines" and was not so intimately involved with her child so as to threaten her attempts for independence.

Most of the other cases worked out similarly. A child was helped when his mother was helped.

Ten mothers returned to the agency subsequently seeking guidance about emotional problems in other members of their family, claiming that they had been helped before. There were no recurrent difficulties in the children involved except in one case—a phobia recurred in a girl 7 years old. This child was referred for private psychotherapy.

#### DISCUSSION

The mother-child relationship is subtle and changeable. It is as durable as the human beings involved. For the young child the mother's influence, beneficial or malignant, is overwhelming. An outsider wishing to help the child will often find the mother an effective medium. She may be more rigid in her character structure than the child, but she is also more easily available, more reasonable and more capable of controlling the child's intellectual, emotional and physical environment.

A disturbed mother-child relationship may go on undetected by the mother over long periods of time. It may require the overt disturbed behavior of the child to bring it into focus and give rise to anxiety in the mother. This in turn may create complications for her as well as difficulties in the emotional development of the child.

Psychiatric intervention at such a time may help the mother return to her previous psychological equilibrium, improve her relationship with her child, and avoid future emotional difficulties for both. It is im-

portant, therefore, that physicians, teachers and mental health workers recognize early emotional difficulties in individuals and refer them to psychiatrists, mental health agencies or child guidance clinics for appropriate help.

#### SUMMARY AND CONCLUSION

This is a brief report of psychiatric work with 50 mothers who had disturbed relationships with their children at a critical time in the child's emotional development. Three cases are presented to illustrate how

brief psychiatric work with the mother may improve the mother-child relationship.

It is thought that such an approach may drastically change for the better the disturbed behavior of the child, may be beneficial to his emotional development, and may possibly help him avoid future emotional complications.

#### ACKNOWLEDGMENTS

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KATHERINE W. DUNLAP, M.S.W.

## Some observations on acute learning difficulties at the college level

Almost every kind of emotional adjustment problem is seen in a college mental health clinic. None, however, can be more puzzling dynamically at times or more challenging to the therapist than those involving difficulties in learning.

A 17-year-old all-A high school graduate of great promise comes to the clinic, sent by the scholarship committee because he insists after the first few weeks in school that he is incapable of doing college work and is determined to withdraw. A senior, an honor student for three and a half years, abruptly loses interest in her goals, becomes withdrawn and is unable to attend classes. A graduate student comes in because he is unable to begin work on a thesis necessary to complete his degree. A potential engineer is panicky because he has repeatedly failed a required course though he

has no difficulty in other studies. Such situations as these, and instances of inability to study, or concentrate, or pass examinations are familiar to every mental health clinic. Parents are distressed; advisers and administrators are frequently puzzled; and the students themselves are often bewildered.

What happens to capable students that they become, at various times in their college careers, unable to function academically?

We know that in some instances a realistic life situation of acute emotional stress, such as a broken engagement, a serious illness or death in the family or a pressing

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Mrs. Dunlap is a mental hygiene counselor in the student health service of Wayne State University, Detroit.

personal problem, so absorbs all the individual's attention that a temporary withdrawal of psychic energy from the intellectual process occurs, and the student then finds himself unable to concentrate or to remember. This type of learning difficulty is familiar and usually is alleviated by supportive treatment.

But there are other instances in which a learning situation, under certain stress, may become attached to a repressed conflict. Then the acquisition of higher knowledge in general, or knowledge of certain content, a particular educator, the writing of an examination or the attainment of a degree may take on the significance of an unconscious forbidden libidinal activity or the meaning of an unconscious aggressive destructive accomplishment. The learning situation then produces an unbearable anxiety against which the student defends himself by an inhibition.

The inhibition may be an acute, isolated reaction in a relatively healthy personality or it may be only one of many chronic manifestations in a total neurosis or character disorder. It is the acute reaction which responds most readily to the type of brief psychotherapy available in most college clinics.

The following histories have been chosen to illustrate this type of inhibition. The student in each case was of good intellectual capacity, had made a satisfactory school and learning adjustment prior to the difficulty, and responded favorably to treatment.

Mary, a 19-year-old sophomore who had done good work her first year in college, came to the clinic at mid-semester for help, she said, in making a decision. She had already withdrawn from three of her classes and thought now that she should drop out of school entirely, take a course in typing and shorthand and go to work to help her

family, whom she felt to be in financial difficulties. She said that her father's theater had been struck by a cyclone in the summer and she felt she should not ask him for school money any longer. She felt that worry over money might aggravate his high blood pressure. She said that her mother also had not been well since hospitalization four years ago following an automobile accident, and added that there was a 16-year-old brother also to be educated.

Further inquiry into the current situation revealed that Mary had missed the first three weeks of school because of an appendectomy; a few weeks previous to that her closest girl friend had died suddenly of an unsuspected cancer; and most recently the first boy she had ever been serious about had jilted her. Mary verbalized freely and easily, and in a couple of interviews the dynamics of the difficulty appeared fairly clear. As the result of a series of emotional stresses, which for Mary had been overwhelming, old infantile fantasies of a destructive nature, previously quiescent, had become reactivated and she was unconsciously experiencing being in college as a destructive activity: impoverishing her father, depriving her brother, making her mother more ill. Withdrawal from school now and the determination to "help" her parents was again, as at age 15, her defense against the guilt and anxiety she was experiencing.

Mary was seen once a week for the rest of the semester. She was helped to see how the hospitalization and death of her girl friend had reminded her of the hospitalization of her mother four years previously, and how this had stirred up the feelings of fear she had had then that her mother might die, and the guilt she had felt because of sometimes inconsiderate and hos-

tile feelings toward her.<sup>1</sup> It was also pointed out to Mary that she was attempting to handle her feelings now in the same way she did four years ago when she stayed home from school to "help" the family; and that while at that time her action might have been realistic, the situation now was entirely different. She was helped to see that in reality her mother was in good health at this time; that her father's financial situation was a very secure one; and that there were better ways of handling her feelings than dropping out of school.

This student developed a strong positive mother relationship to the therapist. With reassurance and encouragement she was able to relive a traumatic and threatening experience and to work through enough of her ambivalent feeling (which included resentful and revengeful feelings against the faithless boy friend also) and gain sufficient insight to enable her to remain in school. Her transcript for the last two semesters shows that she has been able also to return to her former level of school functioning.

The case just described and the two that follow illustrate, among other things, the importance of examining carefully the social setting in which the student is failing and the events just preceding the difficulty. This frequently not only gives a clue to the conflict being defended against but indicates as well how the school situation is being used as a vehicle for its expression.

Tony, a 22-year-old boy of Italian descent, came to the clinic near the end of his junior year asking permission to drop his Italian course for "health reasons." He was a rather passive boy, working his way through college and doing better than average work. He said the instructor "had it in for him." Tony said he felt extremely anxious in the presence of the instructor, was unable to recite or pass

examinations, and had been unable to attend the last two meetings of the class. He felt he was being singled out by the instructor for ridicule and punishment, although he could cite no particular instances of this. He said the instructor was a "very cutting man who could slice you flat."

Tony was seen for three consecutive interviews. He was encouraged to talk about his home life, his father and their relationship. He said that he had never gotten along with his father and that as a result of their conflict he had "renounced his inheritance" and left home before completing high school. In describing his father Tony used the same words and metaphorical language he had used earlier in describing the instructor. The transference to the instructor was so clear from the material that it was interpreted quite directly together with his repetition of the method of solution—namely, to renounce his inheritance (credit for the course) and leave the threatening father (the instructor). With this insight Tony was able to separate the mastering of Italian (his mother tongue) and the instructor from his old developmental conflict, and he no longer felt anxious in the class situation. He reported, subsequently, that he had been able to talk with the instructor, who had proved very willing to assist him with back work, and that he had passed the course satisfactorily. (This was later verified.) The insight was, of course, not of sufficient depth to produce any dynamic or structural change, but did serve in this situation to detach the learning activity from the original conflict so that the stu-

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<sup>1</sup> The earlier repressed feelings and fantasies connected with the hospitalization of the mother when the brother was born, which were much deeper, were not dealt with at all.



dent could again perform realistically in the course.

George, a 26-year-old senior in the College of Liberal Arts, married, with a 5-year-old daughter, was sent to the clinic by his academic adviser. He was in a highly agitated state and had been doing a lot of acting out. He had become enraged at an English instructor and impulsively dropped the course because, he said, the instructor had accused him of using unnecessarily big words to make himself appear sophisticated. Now he found himself so anxious and upset that he was unable to take an important examination in a race relations course scheduled for the following day. The examination was part of the requirement for a fellowship award for which he had been recommended. An investigation into the current situation revealed that the night before George had had an argument with his father on race relations, during which the father had become quite excited, accused George of trying to win the argument by using big words and ended up by taunting him with "So you want your daughter to marry a Negro!" This infuriated George but he had been unable to express any of the anger toward his father directly. He spent considerable time in the interview, however, ventilating his feelings of frustration at not being able to convince his father and expressing bewilderment at his father's inability to accept any new ideas. His father's fondest wish, he said, was to have him do well in college.

It seemed clear in the first interview that this student, still in conflict with his father, was using the school situation as an

instrument of rebellion and displaced anger and was confusing his English instructor with his father, and interracial relationships with the relationship between father and daughter. This was interpreted to George on the basis of the conscious material he presented.<sup>2</sup> He took the examination and received an A grade. On the basis of this and a paper he submitted later he was granted the award. At the end of the semester he reported he had had no further trouble. (His transcript showed three A's and a B.)

Many different types of pressures may act as reactivators of old conflicts. To the still immature 17- or 18-year-old, for whom college represents the final steps in a successful maturation, choosing a vocation or dating for marriage may stir up fantasies which are quite overwhelming. For example:

Joan, an 18-year-old second-semester freshman, was sent to the clinic by her academic adviser because at the mid-semester she was failing a history course for the second time. Joan said she was at a loss to understand why she was failing a subject in which she had received all A grades in high school and which was what she had intended teaching. She claimed she liked history and really knew the material but that on examinations her mind went blank and she could remember nothing. "Deep down," she said, "it seems I don't care if I fail—but I really do." Joan went on to say that she really did not want to come to college and was here because of her parents' insistence; that she was deeply in love and wished only to be married; and that her parents, especially her mother, did not approve of her boy friend—in fact, did not approve of marriage to anyone until she had finished her education. It developed that Joan had

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<sup>2</sup> The unconscious identification of himself as a Negro and the incestuous implications for him in the father's accusation, "So you want your daughter to marry a Negro!" was of course not interpreted.

never discussed her feelings with her parents, knowing already, she said, what their reaction would be. Also, her boy friend had never actually proposed marriage, although they had gone together steadily for over a year and she felt marriage was logical and inevitable.

The therapist expressed the opinion that it was all right for Joan to drop out of college if this was what she wanted to do but that there were better ways of doing it than flunking out, and encouraged Joan first of all to have a talk with her parents. This she did. Much to her surprise, she found they were very understanding, quite approved of her boy friend, and didn't care whether she went to college or not. She also discussed the situation with her boy friend, who made it quite clear that although he was willing, at this point, to become engaged, he would not be in a position to marry for at least two years. Joan was very happy at the turn of events. Now that she wasn't being "forced to become a career girl," as she put it, she wasn't so anxious to leave school and felt sure she would have no further trouble with her history examinations. A week later she reported she had passed her examination with an A grade.

Joan was seen for only three interviews, but one can surmise from the turn of events that she was using the college setting for the acting out of a fantasy, projecting her own fears of marriage and independence. When she was confronted with reality, the purpose of the fantasy was destroyed, and she could then proceed with her college work. (She had had E at the mid-semester and ended the term with a C average, so she must have received an A on the semester examination also.)

Such inhibition as Joan's, commonly seen in first-year students, may not develop until the last semester of the senior

year. Then, in still immature students, the pressure of graduation, with its unconscious meaning of accomplishment, produces an overwhelming anxiety.

Such was the case with Carol, a 22-year-old all-A student in the last semester of her senior year in the College of Education. She was sent to the clinic by her academic adviser because she had repeatedly failed to appear at her teaching assignment. When the adviser expressed concern and asked for an explanation Carol had become withdrawn and uncommunicative. The adviser was bewildered, as Carol had heretofore been one of the school's most dependable and promising students. Furthermore, the adviser was troubled because she felt the school had been put in an awkward position inasmuch as Carol had been accepted, upon the department's high recommendation, for an unusually good position in an eastern school.

To the therapist Carol stated that she liked her teaching supervisor, had no difficulty with the children, and was at a loss herself to explain her sudden lack of all enthusiasm for teaching, except that recently she had felt exhausted all the time and that her assignment further depressed her. It seemed to her now that getting a degree was unimportant and that she would be happier working at some job which made no intellectual demands on her. She knew this would make her parents happier also, as they felt college had made her feel superior and ashamed of them. This Carol at first denied. But as she explored her feelings she was able to admit that getting good grades, knowing things her parents could not understand, spending most of her time in school activities in which her parents could have no part had given her a certain amount of smug satisfaction. She was an adopted child. She deeply resented the fact that her foster parents

had tried to conceal from her her adoption at the age of four. They thought she was too young to remember. She had cooperated in the deception, although she remembered clearly her own mother and older brother and the traumatic circumstances of her abandonment by her mother—her sense of bewilderment and her feelings of anger and helplessness.

Here is a girl who had been able to picture herself as an adult, succeeding in school, preparing herself to take a job, leaving home and being quite independent of her family; but when she was faced with these ideas becoming realities the old unresolved fears of the abandoned little girl, angry, alone, helpless, were more than she could cope with. Further learning, graduation, the out-of-town job, along with the unresolved conflict, had to be defended against.

As in every instance the therapeutic task was to separate the school situation from the repressed conflict. In Carol's case this was accomplished partially by interpretation but largely through the relationship in which the therapist became to her the idealized, understanding, protective mother. Carol returned to her practice teaching, was graduated and accepted the job. She returned several times, however, within the next year to see the therapist and finally accepted a referral for further psychotherapy.

The treatment of learning inhibitions in college students, unlike other problems of emotional adjustment, is complicated by a time element. Results must usually be obtained in a relatively short time if the students' college experience is not to be interrupted. It is important, therefore, to evaluate as quickly as possible the nature

of the inhibition and to determine whether or not short-term treatment seems feasible. Once this has been established and treatment undertaken a variety of insight-producing techniques may be used—clarification, education, use of relationship, interpretation of ego functioning, confrontation with reality, etc.—keeping in mind the therapeutic goal, which is merely to detach the learning situation from the underlying conflict and not to dissolve or make conscious the conflict itself. The effectiveness of any technique, however, presupposes two conditions: first, the spontaneous establishment of a positive relationship between the therapist and the student; second, a correct understanding of the individual dynamics involved—not for the purpose of interpreting back to the student, as is done in a deep reconstructive type of therapy, but to guide the therapist in using the relationship for the best interests of the student.

The nature of the relationship may be outside the therapist's control, especially in instances where the student has been sent to the clinic by an adviser or comes at the insistence of a parent. As to assessing the dynamics, we have at our disposal considerable technical and theoretical knowledge of the general dynamics of learning and of some of the emotional reasons for its interruption.<sup>3</sup> Our problem is how to apply this knowledge to the individual college student who comes to us. Obviously, no prolonged type of exploration is possible. Our speculation as to the meaning of the inhibition, the nature of the conflict defended against, and the personality of the particular student in which it occurs has to be based very largely upon our observation of him in the interview, our knowledge of his current functioning, and the conscious material he is able and willing to reveal about himself and his history.

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<sup>3</sup> See references.



This type of therapy makes considerable demand on the therapist and not all cases are as successful as those chosen for presentation in this paper. We feel, however, that the college mental health clinic is the logical and appropriate setting in which to undertake this treatment. When it is successful it is a most rewarding service, both to the college and to the student. It merits further exploration.

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MARTIN L. KUNDIN, M.S.

LENORE M. SPORTSMAN, M.D.

## A child guidance center's role in the evaluation and placement of infants in adoption

In 1951 the Albany Child Guidance Center and the Church Counseling Service of Albany launched a pilot study of pre-adoption infant evaluation and placement. Until this time the community agencies' practice was to delay placement until the child was "testable." The child, usually illegitimate, was superstitiously seen as a potential "bad seed" from which adoptive parents must be protected. Consequently, the infant was six

months old or more before pre-placement study was attempted. The necessity of institutional or relatively long-range foster home placement in lieu of early adoption heightened the possibility of early emotional damage.<sup>1</sup>

In the initial phase of the project the center agreed to continue the current community practice and evaluate the infant at six months. As the community and placement agencies were able to accept and have confidence in our evaluation, we were quickly able to lower the age of evaluation and adoption to three months and then to one month. In the last two years we have tentatively moved into what we feel is the last step of the project—the occasional placement of infants into adoptive homes directly from the hospital. (This is done on a limited basis for reasons that

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Mr. Kundin is the chief clinical psychologist and Dr. Sportsman the director of the Albany (N. Y.) Child Guidance Center for Psychiatric Services, which is affiliated with Albany Medical College.

<sup>1</sup> Spitz, Rene A., "Hospitalism: An Inquiry into the Genesis of Psychiatric Conditions in Early Childhood," *Psychoanalytic Study of the Child*, New York, International Universities Press, 1945, I, 53-74.

will be discussed later in this paper.) Three weeks after placement we test these month-old babies for the first time.

The success of this project is currently reflected in the recent inclusion of other community infant placement agencies in our program. We now estimate that 95% or more of all infants placed through responsible local placement agencies are involved in the center's pre-adoption program. We have also received facetious complaints from these placement agencies that the surrounding counties are now sending their infants to our local agencies for placement because of our attractive placement practices. In a neighboring county a community placement agency has been putting pressure on their psychiatric facilities for a similar service.

#### METHOD

An infant surrendered for adoption is usually separated from his natural mother during his first week of life. He is then sent to a closely supervised boarding home or a medically directed infant institution, depending on the placement agency's policy. In either case when he is three weeks old an appointment is made with our center for the initial evaluation of the infant. A few days prior to evaluation he receives a complete medical examination by the placement agency's pediatrician. A summary that includes a complete birth and medical history, with additional observations by the social worker, precedes the child. Also included is the social history of both natural parents, indicating their educational level, socio-economic status and cultural background and the significant medical history of their families.

When he is a month old, the infant is brought to the center by the nurse or boarding parent, who accompanies him to the testing room. There the Gesell in-

fant developmental scales<sup>2</sup> are administered by the psychologist, with the psychiatrist observing. Directly following the evaluation the psychiatrist, psychologist and placement agency's social worker discuss the findings and make suggestions regarding placement. The infant is usually placed in the adoptive home within a few days following the initial evaluation. The final decision on the selection of the appropriate adoptive home is always made by the placement agency.

After the infant has been in the adoptive home for a year and before final legal adoption procedures are carried out, the placement agency schedules the child for re-evaluation at the center. A social history on the adoptive family and the child's adjustment to his home is carefully scrutinized prior to re-evaluation. The social worker accompanies the adoptive family to the center, where the child is retested on the Cattell infant intelligence scale<sup>3</sup> by the psychologist, with the psychiatrist and adoptive parents observing. Directly following re-evaluation, the psychiatrist, psychologist and placement agency's social worker discuss the findings and make suggestions.

#### INITIAL EVALUATION

In evaluating infants, if one accepts the "test score" as a finite measure of development, one loses sight of the infant as a growing, striving, interacting entity. At one month a premature infant will usually test low; to predict that he will be slow in developing is rather ludicrous. Thus,

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<sup>2</sup> Gesell, Arnold and Catherine S. Amatruda, *Developmental Diagnosis*. New York, Paul B. Hoeber, 1949.

<sup>3</sup> Cattell, Psyche, *Measurement of Intelligence of Infants and Young Children*. New York, Psychological Corporation, 1940.



we use the Gesell developmental scale as a rather loose frame of reference and as a means of codifying our results.

Our experience has led us to add several items to the scale. These items are in two areas, namely, "strivings" and "frustration recovery."<sup>4</sup> We evaluate the child's recovery from frustration in the belief that the easier it is to comfort a frustrated infant the more stable is his physiologic and emotional development. It is also useful to see how the baby reacts to comforting by the foster mother and how he reacts to comforting by strangers, and to note any differences, especially because of their implications in the infant's initial method of adjusting to his adoptive mother.

Our measurement of strivings is the result of the following clinical observations. Three different boarding homes are used by the Church Counseling Service. Each of these homes rarely has more than one infant at a time, so that the baby gets a full share of mothering. The boarding-home mothers are carefully selected for their abilities with infants. As we became acquainted with these three women, we were struck with the remarkable differences among them. Mother A is the physical type. Bring her an infant and she immediately grabs it, cleans it, feeds it and loves it. When she walks or talks or sits, her body is in constant movement, legs crossing and uncrossing, hands gesturing, voice chattering. Her infants seem to reflect this constant movement; their arms swing, their legs churn and their bodies wiggle. Mother B is the soft reserved type. Bring her an infant and she lays it on the table. The family gathers around admiringly and radiates delight. When the baby is comfortable she will then clean and feed

him. When she is at the center we listen very closely to her comments, since she makes no observations that haven't been well thought out and are highly pertinent. Her infants are "eye" babies. They are contented, quiet infants with eyes that reflect an amazing awareness; in a contented fashion they seem to absorb their environment and communicate through their eyes. Mother C falls between Mothers A and B and her babies seem behaviorally to fall between infants A and B.

It is our feeling that the ability of an infant to absorb and respond in kind to a specific type of handling reflects good mental health. Our experiences with infants from institutions where there is no consistent mother figure have led us to modify our concept of strivings to include the element of purposiveness. It is not that a specific infant is more prone to use his body or his limbs or his eyes, but it is our clinical impression that an infant who is able to utilize one of these modalities with purpose is demonstrating good mental health. Thus, an active infant who, stimulated with a rattle or the examiner's face, seems to focus his activities toward the stimulation, is considered to score high in strivings; a passive infant who, similarly stimulated, focuses directly on the stimulant and passively seems to be trying to reach out, is also scored high in strivings. One might well equate "strivings" with alertness. However, we feel that our method of trying to pinpoint the method of strivings may prove interesting in our planned follow-up study.

A factor that cuts across all items but has no scientific or objective measure is the feeling of comfort or discomfort which the infant precipitates in the psychologist and psychiatrist.

The premature infants present a special problem. If at all possible we insist on

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<sup>4</sup>It should be noted that all infants are evaluated just prior to feeding time.

evaluating these infants at the usual age of one month. With them we are mainly interested in the "stabilizing factor." Since we find as a general rule that our "normal" infants achieve somewhere between the 4- and 8-week level on the Gesell scales and frequently perform items at the 8-week level, we are interested in the premature infant's ability to "mobilize" sporadically and be able, in part, to perform at "normal" level. However, most attention is paid to the infant's ability to be comforted and to relax. A crucial factor is whether he is hypertonic and to what degree. In the event he demonstrates some positive signs of stabilizing, immediate adoptive placement is recommended.

In our five years of experience in evaluating infants we have had two babies whom we diagnosed as deeply disturbed emotionally. Their behavior was similar; both were totally unresponsive limp "lumps." They had not yet been surrendered for adoption. One was brought to the center by his natural mother, a tense, deeply frightened, overactive woman from whom the baby had obviously withdrawn. We did not see the second mother but the reports suggested she had a similar type of personality. Fortunately, treatment was started immediately following both infants' evaluation. In each case our instructions to the placement agency were "Find a woman who has a deep love for babies and who will be able to keep this one in her arms until she can put him down and he falls into a natural relaxed sleep." The prescription was successful; in both cases it took two and a half to three days of constant care to break into the pattern of withdrawal.

We have had several instances of what we considered a mildly emotionally disturbed infant—the petulant, whiney, hard-to-comfort child with a tendency toward

hypertonic or, more usually, limp responses. In all cases this was clearly related to the occurrence of some specific traumatic event in the boarding mother's home—usually a death in the family. We have also noted a close relationship between the hypertonic infant and the amount of drugs used during the labor period.

## THE CENTER'S ROLE WITH THE BOARDING PARENT AND NURSE

We insist that the boarding mother or nurse accompany the infant to the center. We are able to learn much from her about his behavior and development during his first month of life. She invariably compares him to other infants she has cared for. As we get to know these mothers well, we learn to spot areas of anxiety produced by the infant's behavior. During the 5-year acquaintance with the boarding parents, we form a good relationship and are able to involve them in discussing family problems that would have a bearing on their care of the infant. Parenthetically, we have been able to alert the placement agency when there seemed to be a need to stop using a specific boarding home temporarily.

With the nurses our approach is indirect. When we note that a baby is particularly responsive, we ask "Whose favorite is he?" "How did you know?" is the nurses's usual response. We then discuss generally the importance of paying attention and of talking to babies. Initially, most of the infants cared for by nurses were "the silent ones" with the usual baby sound conspicuously absent. The nurses' "talk" to these infants consisted of soothing clucking sound. It is most gratifying to notice the difference in the nurses' behavior now. They no longer "cluck" but speak quite spontaneously to the infants; the difference in the babies' language area currently reflects this.

Throughout these evaluations the psychologist and psychiatrist maintain a conversation designed to further the nurse's (or boarding-home mother's) understanding of the infant's behavior and needs.

#### INITIAL CONFERENCE

As was indicated, directly following the initial evaluation we discuss, with the referring placement agency's social worker, the test results, our observations and the baby's social-medical history. In most instances the placement agency has tentatively selected an adoptive home and several alternates. Our findings are "normal and ready for adoptive placement" for most infants. In the event we feel the infant deviates from the "normal" we define the type of family we feel will best meet his needs. In the deviate category, we consider four basic types: the anxious, the superior, the physically damaged, and the deeply disturbed. Our recommendations for the deeply disturbed infant have been discussed previously.

The anxious infant is tense and tends to over-react to stimuli. Startle reaction is prominent and of long duration. He will frequently fluctuate between bursts of activity and a hypertonic physiologic rigidity. His eyes frequently pop, the body frequently arches. One feels he is holding a rigid spring ready to uncoil. Again each case is individual. When the "anxiety" occurs in a premature infant and is felt to be a normal part of his stabilizing process, no special recommendations are made except to suggest that adoptive parents be calm. When the infant's anxiety is seen as being rather strong and sustained, the center may recommend that the infant be placed as a second child. We feel that a family which has had experience with one baby and has had the benefit of case work supervision will

tend to be less anxious in handling a second child. The social worker is also alerted to the possibility of having to work more closely with this family during the initial adjustment of the infant.

The superior infant is defined as a month-old baby who demonstrates consistent achievement at a 2-month level or higher on the Gesell development scales. We recommend to the placement agency that he be placed in an adoptive home with stimulating parents who will not exploit his superior abilities if they continue to be manifested. Relatively young adoptive parents are usually sought. We are reminded of the first superior infant evaluated at the center; to the placement agency's social worker we communicated our findings and concern that he be placed in a "proper" adoptive home. A few months later the social worker requested consultation on the child. She expressed concern over the mother's obvious anxiety and overprotective behavior with the infant. In the conference the psychiatrist recognized that we at the center had communicated our anxiety about "proper" placement to the social worker and the social worker in turn had communicated this to the adoptive mother. Acting on this assumption the social worker was able to bring out the adoptive mother's fear that she had been given a defective baby and that the placement agency was hiding this fact from her. Subsequent re-evaluation, focused on alleviating the mother's anxieties, demonstrated a marked change in her attitude and a remarkable growth in the infant's capacities.

The physically damaged infant is not seen for evaluation at the center until a clear-cut medical diagnosis has been obtained. Studies of institutionalized children, as well as our own experience, indicate the need for placement outside a chil-



dren's institution with adoptive parents able to accept the damage. If the damage will lead to early death, or if there is permanent gross neurological damage, the baby is institutionalized. The center's role in the placement of physically damaged infants is to help the social worker understand the psychological implications of the infant's deficit and help anticipate the realistic difficulties the adoptive family may encounter. When institutionalization is indicated, the center's role is to support the placement agency's decision to institutionalize the infant and to deal with the placement agency's anxiety.

The need for the psychiatrist to recognize and deal with the social worker's anxieties over placement is crucial. It is for this reason that the last stage—direct placement from the hospital—has been cautiously approached. Our method has been to "stack the cards" by selecting infants with excellent family backgrounds. As the worth of this procedure has been demonstrated and the placement agency has become more secure in doing direct placement, the tendency has been to handle more placements by this method. The center's routine of examining the baby at one month and at one year does not change. The adopting parents rather than the boarding parent or nurse accompany the infant to the center.

It is well to note that despite a philosophy and policy of direct placement, there are many instances where this is not feasible. For example, the initial physical examination of the baby or the condition of the natural mother may suggest the need for a longer waiting period, as in the case of one mother, ready and eager to surrender her child, who tightened up so literally the day before the surrender that she had to be catheterized. She relaxed for normal functioning following an in-

terview in which a decision to postpone surrender was reached.

## RE-EVALUATION

A routine re-evaluation is scheduled shortly before the final legal adoption procedure is carried out; the child is usually between 12 and 13 months old. The primary function of the re-evaluation is to measure the child's intellectual abilities by standardized tests. Since we are a child guidance center, accustomed to seeing a child as a dynamic part of family interrelationships, our re-evaluations go one step further and utilize the formal re-evaluation testing session as a structured opportunity to study the family's interpersonal relationships. Thus, we insist that the entire immediate family accompany the baby to the center.

When the family arrives and gets settled in the waiting room, the psychologist appears and is introduced by the social worker. His function is to form a relationship with the baby. While this occurs, the psychiatrist appears, is introduced by the social worker and sits quietly by, observing the infant. Her function is to note the interrelationships that occur. She may chat with the parents or play with the baby or with a sibling or sit quietly, depending on the situation. When it is felt that the baby is ready, he and the parents are invited to accompany the psychologist and psychiatrist to the testing room. There are specific places for each one to sit. The Cattell infant intelligence test is then administered. During the test the parents are encouraged to talk about the infant. This will be accomplished in a variety of ways depending on the type of parents. With some, no encouragement is necessary; with others, the psychologist might comment on the way the baby deals with frustration, or tries to avoid performing;

with still others, the psychiatrist may start by asking if toilet training has been started or if the child is still on the bottle. In general, the psychologist focuses on the child's behavior in the test while the psychiatrist concentrates on his general developmental progress.

It is rather difficult to describe specifically how to encourage parents to discuss their child and bring out their questions and anxieties. We feel that receiving support within a welcoming setting where professional workers obviously enjoy contact with them and their baby tends to foster discussion that is invariably cut short by lack of time. Parents enjoy talking about their children and in a favorable psychiatric setting will express whatever questions and doubts they have about a child's growth and behavior. Parenthetically, the main conflict they verbalize is about their neighbor's questions: "Is Johnny still on the bottle? Isn't he weaned yet?" or some such nonsense. Evidently when an adopted child arrives in the neighborhood the neighbors automatically assume the role of critics. The psychiatrist's comment to the mother—that she is doing a marvelous job and to keep on loving and enjoying him, that she and not the neighbor is the child's mother—always elicits a sigh of relief and an "I told you so" glance at her husband. The center's role with the parents is to handle all questions that can be dealt with in the time available and to support the parents in the job they are doing with their youngster.

Our experience has highlighted three common patterns of infant behavior. The first we call the "almost" pattern. Here, the infant's approach to testing is tentative. On the Cattell test tasks he "almost" achieves on many items. His handling of material is "delicate"; if we remove a toy from the

infant and offer him an alternate, he freezes and seems to be afraid to accept anything new. We find that this response pattern seems most often to be related to overprotective handling by parents who inhibit the infant's motility. They see the infant as a delicate entity to be protected from all "harmful" experiences. Although most children, given the freedom of the testing room, wander about exploring, this one stays close to his mother. The second type is the overactive infant. He finds it difficult to sustain attention and complete any task. Toys fly; frustration and anger are readily precipitated. We find that this response pattern seems most often to be related to inconsistent handling where the infant is expected to respond to a variety of limits far beyond his capacities. Frequently we find that there is more than one "boss" to whom the infant is expected to respond, that there is an aunt or grandparent in the home undermining mother's confidence. The third type is the fearful infant. He cries easily, withdraws from strangers, and when comfortable is quite rigid in his behavior. He finds it hard to shift from one toy to another and will spend the period, if he is allowed, exploring a single toy. Needless to say, the mothers of these fearful infants are fearful women.

While the foregoing "types" are described as specific entities, we hasten to add that we rarely see these as sharp clear-cut patterns. It is a matter of degree, and the handling of the parents of these infants varies with the severity of the behavior pattern.

In the event that the youngster being tested has an older sibling the psychologist, after testing the infant, leaves the testing room and strikes up a relationship with the older child, who has been playing with the social worker in the reception

room. An evaluation based on the administration of the Despart fables and on our observation of the family group will frequently elicit a picture of the effects of the new baby on the sibling. We have had several instances in which the older sibling has suffered unduly because of the parental need to invest most of their attention in the baby. This is dealt with during the re-evaluation if possible, but more frequently we will recommend to the adoption agency that final adoption be postponed until the social worker has helped the parents with this problem. Our philosophy is that we are dealing with a family unit. We feel we must constantly be on guard lest we become too overprotective of the infant.

The session is terminated with an open invitation for the parents to feel free to return to the center at any time to allow us to share in their child's progress.

## RE-EVALUATION CONFERENCE WITH PLACEMENT AGENCY

Immediately following the re-evaluation session, the psychiatrist, psychologist and placement agency's social worker meet to discuss the center's findings. Any questions raised by the agency's social worker are discussed and a decision is made concerning the advisability of further supervision of the family and retesting or normal adoptive procedures and termination. In our experience about 3% to 5% of the cases have required further case work. At no time has there been the slightest need to consider removing a child from an adoptive home. We have been constantly impressed with the excellence of these homes.

## COMMENTS

In our frequent re-evaluation of the adoption program, we have come to realize the

importance of the role of a "comfortable authority" in infant evaluation and placement. We know that the local demand for this service is not related to our ability to diagnose and pinpoint where a child falls on a developmental scale, since we neither claim nor can do any such mystical feat. We feel that any pediatrician, nurse, psychologist or social worker experienced with infants can spot an uncomfortable child. The fact that our psychiatrist is a trained pediatrician adds the dimension of a clear concise recognition of the physical factors involved. Add to this the layman's mystic interpretation of the value of a psychological test and our service is vested with authority.

We feel that assumption of the role of "comfortable authority" is the essence of our service. The placement agency, the boarding parents, the nurses and the adoptive parents know we love and cherish and take pride in each of the infants just as they do. We are comfortable in the work we do and they are comfortable in sharing the work they do with us. We do not feel this reflects complacency but a genuine belief in the capacities and wonders of the infant.

## CLINICAL FINDINGS AND MENTAL HEALTH

It was not until recently that we became aware that no infant we have seen, except those with known neurological damage, has rated below I. Q. 100 during retest at 12 to 14 months on the Cattell scale. A project to retest at the age of 5 and 8 years is now in the formative stage. We have also been impressed with the relatively excellent mental health of all the infants we have re-evaluated. Our experience has led us to wonder if these measures of preventive care could be carried over into the community



of natural parents and their infants through a purposive educational effort. Our experience offers hope for achieving a reduction in mental retardation and an improvement in the mental health of families.

#### SUMMARY

A method of integrating the skills of a child guidance center with those of an adoption agency has been described. Infants were evaluated and placed with adoptive parents prior to the child's fifth week of life. They were re-evaluated between twelve and sixteen months of age. The parents and siblings were included in the re-evaluation process.

The guiding principles of this program are fourfold: 1) the earliest possible adoptive placement of infants, 2) the identification of atypical infants and the definition of their special needs, 3) support, recognition and handling of the placement agency

social worker's anxiety, and 4) support, recognition and handling of the adoptive parents' anxiety concerning their child.

Clinical impressions of the children participating in this program suggested superior mental health. Intelligence testing at the time of re-evaluation suggested positive significant differences in the level of intelligence of these children compared with the normal curve of I. Q. distribution. There are indications that this process of adoption contributed significantly to the mental health and to the maximal utilization of the intelligence of these infants.

It is postulated that this service falls within the educational and prophylactic function of a child guidance center and that this service is a definable service which can be duplicated in any community.

The question has been raised as to the value of similar services for natural parents and their infants.

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A. B. ABRAMOVITZ  
ELAINE BURNHAM

## Exploring potentials for mental health in the classroom

An attempt will be made here to describe concisely the experience of three clinical psychologists in planning and teaching an experimental mental health course given concurrently at three state colleges (La Crosse, Stevens Point and Whitewater) several summers ago. In the present paper we are limiting ourselves primarily to an expression of our impressions, feelings and reactions.

Despite the very complex and difficult phenomena involved, the essence of the underlying philosophy and intent of these courses can be simply and briefly stated. This philosophy has been aptly expressed by the mental health committee of the U.S. Office of Education: "The theory that teachers tend to teach as they are taught applies with equal force to mental health. Unless teachers are prepared to teach and

practice under conditions favorable to mental health they are not likely to understand what it means to children to work in a favorable emotional climate. Indirectly, therefore, the road to mental health for children is mental health for teachers. This is not to suggest that most or even many teachers are neurotic, but it is to suggest that the situation can be and is being improved."<sup>1</sup>

Another fundamental aspect of the thinking underlying our experiment is very effectively brought out by Murphy and Ladd:

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Mr. Abramovitz is director of the division of child guidance in the Wisconsin State Board of Health, and Miss Burnham is a clinical psychologist there.

<sup>1</sup> Committee on Academic Education, American Psychiatric Association, Information Memo No. 3, May 1953.

"When emotional factors in learning are seen to be important not only in problem cases but also in a large proportion—if not all—of the student body, guidance becomes a preoccupation of every day, rather than the subject of a semi-annual visit to the dean."<sup>2</sup>

One of the purposes of the summer project in the colleges was to provide in-service training for psychologists in the techniques of mental health education. This is an important function for which original professional training provides very little and for which in realistic job situations there are imposing demands. Most of what psychologists and other clinicians acquire in pertinent skills is usually on a trial and error basis in on-the-job experience.

A second purpose was to find ways to increase the practical value of mental health materials and concepts to teachers in regular classroom work.

The courses were set up for the full six weeks of the summer session. Enrollment was limited to about twenty experienced teachers at each of the participating colleges. A mild selectivity was exercised in admitting the teachers to these courses.

In the catalogs the course was titled Classroom Use of Mental Health Teaching Devices. The focus was deliberately placed on the teachers' everyday class situation with special reference to applying mental health insights and principles, rather than on case studies of children with problems. This was even more specifically channeled by emphasizing the use of such teaching aids as filmstrips, mental health plays, motion pictures, publications with significant psychological content, children's phonograph records, etc. The courses were con-

ducted primarily through informal discussions, laboratory-like exploration of the teaching materials, and some practice-teaching opportunities with children in laboratory schools. The fundamental assumption was if the instructors through their methods and relationships with their students conveyed sound mental health concepts and practices, the students would be enabled to convey the same to the children in the practice-teaching groups.

Since these courses were an exploratory attempt and a new experience for the instructors as well as the students, it was felt that the most logical and desirable first step in evaluation would be an unstructured conference shortly after the close of the courses. The three instructors would be the only participants and they would have an opportunity to exchange their feelings and reactions extemporaneously. On the assumption that these three psychologists represent a fairly typical sampling of such personnel as may be found in child guidance clinic work and that the gap between classroom teaching and clinical understanding (which we were trying to learn to bridge through this project) represents a significant and fairly universal problem, it is deemed worth while to present a considerably abbreviated version of this conference. Probably educators will be just as interested as clinicians in these deliberations.

The very first question that arose and seemed so basic to all that followed was whether clinicians and teachers have a common understanding of the very meaning and nature of the teaching-learning process. What is teaching? What is learning? How do these occur? As psychologists we felt that learning involved something broad in its effect on the personality and behavior of the learner. In contrast, we wondered whether the teacher is more concerned with

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<sup>2</sup> Murphy, Lois B. and Henry Ladd, *Emotional Factors in Learning*. New York, Columbia University Press, 1946.



seeing a fairly good response to a specific stimulus and less concerned with change in the situation. The concept of learning as a specific response to a definite stimulus merely carries with it a predetermined objective of the teacher. The teacher wants the student to learn a fact or method which she has assumed in advance is desirable for the student to learn. Often now, always teachers try to have pupils participate freely and purposively in learning. Such democratic classroom procedures may, however, obscure the fact that the learning may fail to become a vital part of the pupil as a person.

It was noted that there would probably not be any significant disagreement as to concepts of learning and teaching between the clinicians and the teachers on a verbal or intellectual level. Yet under the pressures of actual teaching the practice seems to differ from the theory. Obviously there are enough individual differences among teachers and sufficient variability of any individual teacher that this is not a black and white discrepancy. We wondered what might be the outstanding cause of failure to apply consistently in practice what was agreed with verbally. Might it be the individual teacher's feelings and attitudes perhaps more than any other factor? In essence, **it seems that the pupil learns as he is taught rather than according to any theory the teacher may profess.**

We found in the three courses that most of the teachers had a great deal of previous experience that ran counter to the procedures and thinking guiding the instructors, who were trained as clinical psychologists. A number of the students showed strong resistance—a few even dropped out of one group during the first week. Much of the resistance seemed to center about the fact that the instructor was not giving the customary reassurance

that there would be either reasonable amounts of debate right or wrongs to the questions being considered. For certain, in carrying this kind of flexible and indelicate structuring of a learning situation is very threatening and anxiety producing.

Frustration was expressed by the psychologists over the fact that in a teaching learning situation of this type a 6-week period was very short to expect much progress. Some of the frustration was caused by recognition that others working with **this problem have noted it takes a long time to achieve a good effect and there is no way to make satisfactory short cuts. We were glad we could reduce our own anxiety over this so that our uncomfortable feelings did not make things more difficult for our students.** In a sense this is one of the most important mental health concepts we could wish for teachers to grasp: that they try to avoid injecting into learning situations (even subtly) anxious pressures to speed up a process that needs to take its own natural course at its own appropriate rate.

In continuing to explore the meaning and nature of learning and change in the learner, the question was asked whether it is possible to make a deliberate change in any student through teaching. It seemed to us possible for the teacher to prepare the ground, so to speak, and to help with planting the seed, but the rest seemed to depend primarily on the learner. However, just as the teacher may facilitate a change in the learner so may the teacher hinder change.

As we observed the teachers in these courses it seemed that many of them wanted to have learning take place through the presentation of factual material for the pupils to absorb and repeat. Rather subtle and complex difficulties were encountered in the teachers' attempts to break away from such an approach. The teachers

seemed to manipulate the learning situation and to implement the manipulation by pressures of one kind or another to induce, cajole or even force change in the learner, no matter how limited a change might be. Even in dealing with emotionally-charged materials such as mental health films, the teachers adhered closely to the limited objective of producing intellectualized understanding and response to content, while remaining relatively unconcerned about the learner's feelings, attitudes and functioning as a whole person.

From the clinician's standpoint "good learning" depends considerably on a learner's genuinely accepting and taking responsibility for his own behavioral change. We wondered whether that does not contrast sharply with what happens in many classrooms. How many teachers would say that a condition of genuine learning is that all pupils in the class must somehow have achieved a state in which they have not only acknowledged, but also worked through, their responsibility for their own learning? There is frequently confusion as to what constitutes responsibility. Often lurking in the background is a concept of "will power," some kind of conscious volitional activity. It is thought that this will power can step up quantitatively the child's use of his innate capacities, his motivations and so on. In this summer project we learned that for some teachers there is a basis in their own life experiences and educational background for this great emphasis on the volitional stepping-up process. When there is overemphasis on the factor of will power there is likely to be a concomitant omission of regard for all the dynamic emotional forces that are part of the natural fabric of learning.

When one has too simplified, too rational,

too intellectual a view of learning one thinks of applying more energy of some kind as a means of overcoming obstacles in a rather direct one-to-one logical relationship. For example, if all that is essential in learning to read is to pay attention or try hard enough, and the child does not learn, then the rational, intellectual solution is simple enough: All that is necessary is to turn on the control in higher degree, to pay more attention, try harder and overcome the obstacle. But the clinician feels that the forces determining learning, both quantitatively and qualitatively, are not so direct, nor so logical nor quite so open to conscious control. Paradoxically, some of these logic-based solutions may be totally illogical and inappropriate.

Clinicians, varying individually of course, will in one way or another, to one degree or another, have some of the teachers' orientation to learning. It may be to the benefit of all that clinicians do have some of these intellectualized attitudes in common with others. Otherwise, clinicians and teachers would have less adequate means of communicating with each other. Perhaps one of the first things that takes place in trying to overcome the gap between clinicians and teachers is some kind of identification based in part on communication through shared attitudes. For this to occur it is necessary that the clinicians should have outgrown certain attitudes and have gained insight into and objective understanding of the same attitude problems in other people. This will better enable the clinicians to be non-judgmental and genuinely helpful to others.

As a matter of incidental significance, the question might be raised whether clinicians, generally speaking, have been attracted to their field of work at least in

part because of conflicts related to the traditional type of education.<sup>3</sup> If this is true, clinicians may be in a defensive role when they have to deal with educators, particularly in the role child guidance clinicians commonly play (that is, mainly as interceders for the well-being of children who are in conflict with educators). If the people in teaching have been attracted to their profession because of factors in their own background which have made traditional education congenial to them, they will likely be defensive in relating to clinicians, especially over the common problems of children who present learning or educational difficulties of any kind.

An assumption basic in setting up these courses, in the light of just such considerations, was that teachers would have to begin at the point of becoming sensitized to themselves and their own educational experiences, broadly speaking. Obviously there can be no special technique or direct approach even to setting in motion such a process of sensitization. Furthermore, since this was not a therapeutic procedure, but rather educational, a careful attempt was made to avoid turning this into too personalized an experience and to avoid probing or insight-giving on a personal level. Accordingly, the focus was more generic, concerned with teachers as professional workers. We felt this focus would open up the possibility for each teacher to apply to himself or herself whatever seemed fit, and go as far as he or she wished and comfortably could. It did not seem at all surprising then that we found—regardless of the chronological or professional age of the individual—well established defenses brought to bear on all phases of the course. The instructors felt it very important to respect and safeguard these defenses that the teachers called into

play. We believed that for all practical purposes the most that could be achieved was to help them utilize as much or as little as they could within the framework of their own defense systems. From one standpoint this proved to be difficult and frustrating for the instructors since progress under such circumstances was extremely slow and in some instances almost imperceptible.

There was one place where the defense systems were challenged. This related to the teachers' tendency to abstract individual problem children from the class for special concern and attention on the basis that these children deviated from a pattern that was thought to be desirable and to which the majority of pupils seemed to conform. From material we gathered during the course it seemed obvious that the chief basis for this attitude of the teachers was their own relative success in using conformity as a defense. This defense, in other words, was being projected on the so-called problem children in their classes. The instructors challenged this by focusing firmly and consistently on the need to be concerned with all pupils in the class and on seeking ways to help even the deviates through the general classroom procedures. For some of the teachers this challenge was difficult and conflict-provoking. Even in the short period of the 6-week summer session, however, it seemed possible at least to help them over the hump of this conflict.

There was wide variability among the teachers in the three courses in chronological age, years of teaching experience, and

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<sup>3</sup> Bloch, Donald A., "Some Concepts in the Treatment of Delinquency," *Children*, (March-April 1954), especially 53-54.



even formal professional training. In the opinion of the instructors, none of these factors seemed to determine how effectively the teachers either perceived and utilized what the course had to offer or what they were able to do along the same lines themselves even before they took the course. A much more important determinant seemed to be their capacity to think about and react to children in a manner that may be termed dynamic. This means the capacity to understand and respond to children in ways that go beneath the surface and purely rational level, the capacity to understand cause-and-effect relationships in children's behavior, to give adequate recognition to feelings and attitudes and the "meaning behind words."

The fact that teachers are often men and women who have gone through difficult adjustments in their own lives stood out in the observations of the instructors. Furthermore, they seemed to have a good deal of ego strength in either overcoming their problems or learning to live with them. They seemed to be eager to help children either avoid unhappy problems or overcome them with the same ego power they themselves had been able to muster. It is not surprising that since so much of their own control over their problems is intellectual, they would like to transfer the same intellectual capacities to their pupils. These are observations the instructors made and for which some sub-

stantiation was obtained in less subjective ways during the summer course.

Since it is unlikely that many children will show these unusual capacities—apart from the question of whether it would be desirable—we felt that we had identified here a great stumbling block between teachers and their ability to promote mental health and good learning in their pupils. We have no easy or ready solution. We would suggest, however, that perhaps an ongoing program during original training and an in-service training attempt to help teachers to be more objective toward pupils—in the sense that they not project upon them their own problems or modes of solution—would be of considerable value toward removing the stumbling block. Another conviction strengthened through the summer experience was that the challenge to teachers to focus less on the abnormal and unusual situations of some individual pupils and more on the group teaching process in the classroom would also help considerably.<sup>4</sup> Finally, the conclusion was reached that helping teachers to understand cause and effect and meanings in children's behavior would in the long run prove extremely valuable. It should also be reiterated that we felt more strongly than ever the truth of the view that "although there is a priority of need for teachers to understand the social and emotional aspects of child development, it is clear that understanding on a conceptual-verbal level is insufficient."<sup>5</sup> "Self-knowledge in depth" as a basis for both teaching and learning seems not only essential but also realistically possible.<sup>6</sup>

#### ACKNOWLEDGMENTS

We would like to acknowledge here our gratitude for the excellent cooperation given by the three colleges as well as by the Board of Regents of Wisconsin State Colleges. We also wish to express gratitude to Norman Brown of Kalamazoo, Mich., for

<sup>4</sup> Sanford, Fillmore H., "Psychology and the Mental Health Movement," *American Psychologist*, February 1958.

<sup>5</sup> School of Education, University of Michigan. Proceedings of the Conference on Human Relations and Human Development, 1953.

<sup>6</sup> Kubie, Lawrence S., "Psychoanalysis and Marriage," in *Neurotic Interaction in Marriage*. New York, Basic Books, 1956.

# Mental Health in the Classroom

ABRAMOVITZ AND BURNHAM

his considerable share in this experiment, both in teaching one of the courses and in helping to do the evaluation on which the present paper is based.

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HANNAH D. MITCHELL, R.N., M.P.H.

# Making interviews by public health nurses more effective

The Georgia Department of Public Health has endeavored to bring about a more practical and profitable use of public health nurses in direct and indirect mental health activities. Increased funds for

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Miss Mitchell is assistant to the director of health conservation services for the Georgia Department of Public Health.

<sup>1</sup> Beasley, Florence A., "Public Health Nursing Services for the Families of the Mentally Ill," *Nursing Outlook*, 2(Sept. 1954), 482-84.

Beasley, Florence A. and William C. Rhodes, "An Evaluation of Public Health Nursing Services for Families of the Mentally Ill," *Nursing Outlook*, 4 (Aug. 1956), 444-47.

Rice, Guy V., "The Role of the Public Health Nurse in the Hospitalization of Mental Patients and Their Follow-Up After Discharge," *American Journal of Public Health*, 47(Feb. 1957), 210-214.

mental health programs since the passage in 1946 of the National Mental Health Act has made such effort possible. Supportive services to families of the mentally ill by the public health nurse in Georgia is illustrative of what has been accomplished without elaborate expenditure of funds.<sup>1</sup> The public health nurse is currently receiving in-service training in interviewing which is economical and yet pays tremendous dividends in interpersonal communication.

The nurse is constantly in the process of developing patient interviews. The question was raised by one of our psychiatric consultants as to the impact on the mental health of Georgia's people if the public health nurses could be taught to listen to patients. At about the same time, a maternal and child health director recog-



nized that the interviews in the maternal and child health conferences were not the best that could be desired. Public health nurses themselves asked indirectly for instruction in interviewing when they asked how to get patients to talk and when they said patients failed to pay any attention to what they told them.

Joint planning began with committee representation from the maternal and child health, mental health and nursing divisions. It was decided to hold a series of workshops on interviewing with members of the central state health department staff and supervisors from local public health departments with the idea that if these were successful similar workshops on regional and local levels would be held.

Two objectives for these workshops evolved:

- Improving services to patients by increasing the ability of public health workers to communicate. Such an undertaking would prepare the nurse to assume a more pronounced listening role. The matter of listening to the patient would in itself be a service and would open areas whereby assistance could be rendered to the patient.
- Providing an opportunity for all medical, nursing and nutrition personnel in administrative, consultant and supervisory public health to increase their understanding of the essentials, techniques and skills in interpersonal communication by focusing on the subject of interviewing.

Consultants were brought in from U. S. Public Health Service, Children's Bureau, Emory University and other outside agencies to assist in giving didactic material and to observe live interviews and provide consultation to the interviewers afterwards.

The workshop focus was the expectant mother but it was realized that the principles applied equally to all types of interviews. The expectant mother was chosen because the public health nurse devotes much of her time to this group and because these interviews sometimes become a matter of the nurses "telling" the patient rather than "listening."

The first workshops were not limited to nurses but included other disciplines such as physicians and nutritionists. Several workshops of four days each were held since all of the above personnel could not come to one meeting.

Considerable anxiety, in both individuals and groups developed in some of the groups. It is our desire to follow these groups to determine the relationship between anxiety and follow-through.

Some of the elements of the patient-worker relationship considered were:

1. The structure of an interview.
2. The essentials—the "musts" of an interview; the atmosphere conducive to conducting a satisfactory interview.
3. The techniques—tools used in an interview.
4. The skills—adeptness or ease in using the techniques.

Those participating in the discussion of anthropological factors came to realize the difficult barriers between those of differing cultures. This understanding brought a greater opportunity to transcend such obstacles in the relationship between the patient and the worker.

The value of silence by the worker and of non-verbal communication by the patient were considered. In some observed interviews, the interviewers prolonged the socialization relationship. Quite

a few did not recognize the patient's right to terminate the interview.

How did the various groups feel about their part in the workshop? The patients expressed an appreciation for having time to talk out some of their problems, and one or two returned to subsequent workshops. At the beginning of each workshop some of the participants felt they needed no further preparation in interviewing. A few asked for observation of an interview by an "expert." There was resistance by the consultants about filling such a request. The consultants were fearful that the participants would feel it should be a "perfect interview." An attempt was made once to meet this request. The consensus after the staged interview was that "the only way to learn how to interview is to interview." Most of the participants enthusiastically felt that skillful interviewing brought much satis-

faction to the worker. There was a general feeling by the participants that they were learning how to get from the patient information about her feelings and her problems. All became aware of the non-verbal elements of communication.

Following the workshops we have noticed a considerable increase in skilled interviewing by participants. Two similar workshops have been held on a regional level and one in an urban community. Continuing interest has been expressed by many individuals.

We believe that greater facilitation of communication is one of the principles involved in the promotion of good mental health. The training described, while it cannot be definitely measured, improves communication between the professional worker and the patient and thereby adds to the general mental health of the community.

# Treated sex offenders and what they did

This paper is an interim report based on data being assembled over a 5-year period on factors in recidivism among psychiatrically treated sex offenders. To date there has been an excess of conjecture rather than documented fact from both a medical and legal standpoint on the issue of sexual psychopathy. The Atascadero State Hospital, opened in June 1954, offers a unique research opportunity because it was designated as the one California facility for the observation and treatment of sex offenders in accordance with statutory requirements.

It is usually assumed by the general public that the molester of female children is an old man more or less in his dotage, that an incestuous relationship between father and daughter seldom occurs, and that such a relationship between father and step-daughter also is rare. The molester of

male children is assumed to be the middle-aged tramp or hobo who entices little boys into culverts or vacant buildings. These assumptions are exploded by examination of the records through October 31, 1957 of 1,114 convicted sex offenders who were discharged from Atascadero State Hospital after psychiatric treatment with a statement to the committing court that the patient had improved and was no longer considered a menace to society.<sup>1</sup>

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Mrs. Frisbie is a psychiatric social worker for the California State Department of Mental Hygiene assigned to Atascadero State Hospital. Her paper expands pertinently on the general information supplied by Paul Kivisto in his article, "Treatment of Sex Offenders in California," in *Mental Hygiene*, 42(1, 1958), 78-80.

<sup>1</sup> Section 5517-b, California Welfare and Institutions Code.



Under the California law on sexual psychopathy<sup>2</sup> the superintendent of the Atascadero State Hospital has the privilege of selecting for treatment only those convicted sex offenders who are deemed treatable and who qualify under the law as having a pattern of abnormal sexual desire and are a menace to the health and safety of the public. The child molester is the prototype of this definition and thus should properly make up the largest group of Atascadero State Hospital patients.

The first discharges from this hospital during 1954 and early 1955 comprise those patients who were originally admitted for observation and treatment at Mendocino and Metropolitan State Hospitals. The philosophy and interpretation of the law by the superintendents and staffs of those hospitals was somewhat different from that

at Atascadero State Hospital in respect to an offense of rape or assault with intent to commit rape on adult females. The superintendent and staff at Atascadero State Hospital usually regard these sexual offenders more properly as criminals within the meaning of the law, for in such cases the offense ordinarily represents absence of control over normal temptation and normal sexual desire. Furthermore, we consider the precise definition of the legal term *sexual psychopath* as inapplicable in instances of homosexuality between two adult males where there is in effect a willing partner, not a victim. This is private abnormality, not publicly menacing behavior. It is therefore obvious that among the patients committed to Atascadero State Hospital for observation and treatment a minimum number will represent those convicted of rape of the adult female or of adult homosexuality, and presumably only when such convictions are symptomatic of a pattern of other uncon-

<sup>2</sup> *California Welfare and Institutions Code and Laws Relating to Social Welfare*, Sacramento, 1955. See Division 6, chapter 4, section 5500, page 283.

TABLE 1

*Frequency of type of sex offense*

CHARACTERISTIC OF OFFENSE	NUMBER OF CASES	PERCENT OF CASES
<i>Physical contact</i>	905	81
Molesting child	846	76.0
Molesting adult female	49	4.0
Molesting adult male	10	1.0
<i>No physical contact</i>	209	19
Indecent exposure	136	12.0
Vagrancy *	27	2.4
Peeping Tom	18	2.0
Transvestism and/or stealing women's lingerie	13	1.1
Lewd telephone calls	10	1.0
Arson	4	0.4
Possession of narcotics	1	0.1

\* Includes masturbating in car; loitering in park or near swimming pool or school grounds; masquerading as a woman.

trollable neurotic sexual misbehavior. The effect of this selection process will be more clearly disclosed as the volume of discharges increases.

The degree of neuroticness is debatable in those sex offenses where there is no physical contact. Society, however, is annoyed by the habitual exhibitionist who mocks propriety and convention, the Peeping Tom who invades privacy, and the maker of lewd telephone calls who forces his vulgarity upon a victim usually selected at random. Obviously these persons have abnormal and uncontrolled desires. Incarceration in jail or prison serves no useful purpose since the deterrence factor is not applicable to the man who has neurotic compulsive behavior. Treatment in a psychiatric setting serves society more advantageously.

For purposes of clarity, in Table 1 the categorizing of patients by type of sex offense is in arbitrary groupings according to physical contact or no physical contact. Of 1,114 cases, 76% are child molesters.

In Table 2 the age of the patient is computed in relation to the date of his admission to Atascadero State Hospital. This is reasonably accurate in assessing the patient's age at the time of his conviction

TABLE 3

*Frequency of child molestation by sex of victim*

SEX OF VICTIM	NUMBER OF CASES
Girls	579
Boys	229
Girls and boys	36

because the pre-trial jail period rarely exceeds 90 days and is usually shorter. Hospitalization follows rapidly after the superior court hearing on the issue of presumed sexual psychopathy. Among those cases transferred to this hospital from Metropolitan and Mendocino State Hospitals, however, the patient would actually have been younger when the crime was committed because the admission date to Atascadero State Hospital is less closely related to the conviction date.

It is apparent that these sex offenders are predominantly young men whose median age is 36.7 years with 59.4% of the total number falling into the age group below 40 years. This closely parallels findings on British sex offenders where 64.6% in a study group of 1,985 men were under 40 years of age.<sup>3</sup>

Special attention will be directed to the characteristics of the child molester since these men represent 76% of our study group. The actual conviction may represent an offense varying from one extreme of holding a child on the lap and/or kissing him or her, through digital manipulation of the genitalia, to forcible rape. Whatever the act, there is assumed to be some degree of sex gratification experienced directly or indirectly by the child mo-

TABLE 2  
*Age distribution of sex offenders*

YEARS OF AGE	NUMBER OF CASES	PERCENT OF CASES
15-19	25	2.2
20-29	314	28.2
30-39	323	29.0
40-49	179	16.1
50-59	190	11.7
60-69	93	8.3
70-79	46	4.1
80-89	4	0.4

<sup>3</sup> Radzinowicz, L., *Sexual Offences—A Report of the Cambridge Department of Criminal Science*, New York, Macmillan Co., 1957, p. 115.

lester. The ratio of cases of molestation of girls is approximately  $2\frac{1}{2}$  times as frequent as molestation of boys, but it must be remembered that in many cases of both sexes there is more than one victim.

That the child molester is not necessarily a senile old man becomes clearly demonstrated in Table 4. Fifty-three percent of the child molesters are under 40 years of age. This is compatible with the

TABLE 4

*Age distribution of sex offenders comparing all offenses with child molesting*

YEARS OF AGE	ALL CASES	CHILD MOLESTING CASES
15-19	25	13
20-29	314	191
30-39	323	247
40-49	179	147
50-59	130	116
60-69	93	85
70-79	46	43
80-89	4	4

median age of 36.7 years for all sex offenders in the study group.

To what extent is consanguinity a factor among child molesters and female victims? No attempt is made here to differentiate between fondling and actual incest with penetration because of the lack of uniformity by the courts in the application of the term incest.<sup>4</sup> For study purposes, then, all daughter and stepdaughter victims are categorized broadly as child molestation

TABLE 5

*Frequency of consanguinity among female victims*

RELATIONSHIP OF VICTIM	NUMBER OF CASES
Daughter	98
Stepdaughter	56
Daughter and male child	8

cases and represent 26% of the total child molestation cases involving females. In one-third of the 98 cases involving a daughter, the father (patient) was between 30 and 35 years of age.

The median age of the child molester's female victim is 8.8 years and of the male victim is 12.3 years. The total number of victims in Table 6 is based on statistics through August 31, 1957 and hence does not coincide exactly with figures cited previously.

TABLE 6

*Age and sex of victims of child molesters*

AGE OF VICTIMS	SEX OF VICTIMS	
	Girls	Boys
0-2	7	0
3-5	76	12
6-8	228	44
9-11	192	67
12-14	71	108
15-17	18	39
18-20	2	1

## SUMMARY

The findings in this inquiry<sup>5</sup> show:

1. Eighty-one percent of the offenses involved physical contact.

<sup>4</sup> Deering's Penal Code of the State of California. Revised 1949. Section 285, page 85.

<sup>5</sup> For an earlier report, see Louise V. Frisbie, "The Treated Sex Offender," *Federal Probation*, 22(March 1958), 18-24.



2. Seventy-six percent of the offenses represented child molesting.
3. The median age of the sex offenders was 36.7 years.
4. Approximately  $2\frac{1}{2}$  times as many girls as boys were victims of the child molester.
5. Among the cases of female victims of child molesters 26% were daughters or stepdaughters.
6. The median age of the female victim of the child molester was 8.8 years.
7. The median age of the male victim of the child molester was 12.3 years.

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GERALD CAPLAN, M.D., D.P.M.

# An approach to the education of community mental health specialists

The Harvard School of Public Health program of education for community mental health specialists has been developing over the last five years as a special endeavor of our mental health section. This section was established ten years ago under the direction of Dr. Erich Lindemann for the primary purpose of providing instruction to public health students in the principles of community psychiatry. Our approach to the education of mental health specialists has been much influenced by our collaboration in this program with our

faculty colleagues from other departments of the school, and also by our need to reformulate our psychiatric ideas to fit them appropriately into the frame of reference of our general public health students.

It may be well, however, to emphasize that our current thinking is fundamentally based upon our own clinical experience and researches, which over the years have been moving steadily from their early focus on the psychosomatic pathology and the psychotherapeutic and psychoanalytic treatment of the individual patient to an interest in the etiological forces in his social environment, and then on to the possibility of controlling these noxious factors in order to lower the incidence of mental disorder in a community. Our approach to community mental health is focused mainly on the organization of specific pro-

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Dr. Caplan is associate professor of mental health and head of the mental health section at the Harvard School of Public Health. He delivered this paper at a conference on training for the community mental health professions, organized by the California Department of Mental Hygiene and held August 24-27, 1958 at Berkeley.

grams for the prevention of mental disorder, and although the planning of these programs is directed towards the study and management of factors at the community level, our appraisal of these factors is colored by our old clinical frame of reference, and many of our operating techniques are derived from individual psychiatric practice.

I draw attention to this aspect of the development of our approach because it is linked to two major problems which today face the student of community mental health and his teachers.

Firstly, there is the need to define a manageable area of the field which can be made the primary focus of study. Recent thinking which emphasizes that "positive mental health" involves something much more than merely the absence of mental disorder, while certainly valid, may imply widening the universe of discourse to include so vast an area that planning a curriculum becomes almost impossible. By narrowing our focus to the prevention of recognizable mental disorder we have carved out for ourselves and our students a part of the field in which we can hope to achieve specialized competence, and across the borders of which we can offer collaboration to the many other professions who have a stake in positive mental health.

The second problem derives from the need of the clinician who has previously focused on the individual patient to acquire new frames of reference in order to comprehend community factors and their modification. Most of us clinicians who have specialized in community mental health have passed through a rather painful and difficult phase of professional development as we have come to the surprised realization that the frame of reference of psychodynamic psychology and

psychopathology, which served us so well in dealing with individuals, was quite inadequate in conceptualizing the dynamic factors influencing the group and the community. Whence then were we to derive the additional conceptual tools and skills? Many of us quite naturally turned for help to those professions which had traditionally been operating at the community level, to the social scientists and to the members of the public health professions—the epidemiologists, the biostatisticians, the health educators, the public health administrators and the other community practitioners. As one might have expected, we have not found that any of these professions has been able to give us specific answers to very many of the questions we have felt it important to ask. Each of these professions has developed conceptual frameworks and ways of operating which have been designed to answer questions important to themselves. We can borrow something from most of them, but in the final analysis the concepts and techniques we can profitably use for our own professional needs must be developed within the context of our own professional reality.

Although the various community sciences and professions can provide us with few ready-made answers to our questions, they certainly have much of value to offer if we can adapt their tools to our specific purposes. The problem for the community mental health student and his teachers is how deeply to delve into the mysteries of each and how to avoid becoming utterly confused by the acquisition of quite different, although to the outsider deceptively similar, frames of reference and conceptual systems.

This is an emotional as well as an intellectual problem, and we believe it is basically a question of the worker's ac-



quiring a new professional identity<sup>1</sup> as a community mental health specialist. When security in this identity develops, it is possible to view with clarity the systems and concepts of other professions and sciences and to borrow and adapt ideas of potential value without feeling and behaving like a dilettante.

The difficulty at the present time is that although community mental health programs have been in operation for many years there are still too few established specialists to act as an adequate professional reference group and no distinct professional identity has as yet emerged which a student may incorporate. We therefore have largely to fall back on individual role models, and this leads to the danger of cultism among disciples who may wish to escape from the insecurity of our present ignorance in this field by placing their faith in the words of the master. This is a danger which must be borne in mind not only by students, but even more so by their teachers.

At Harvard we have adopted one other approach to this problem, and that is to make use of the opportunity presented by our operating within the framework of a school of public health. The profession of public health carries its own professional identity which transcends the identity of the component professions and sciences. One of the goals of such a school as ours is to enable all its students, whatever their background and future specialty, to incorporate this basic identity. We feel

that until community mental health has developed a professional culture of its own one of the ways of helping our students to incorporate the community approach is to encourage them to become public health men. In line with this, we have advised our students to attend a variety of courses at the school, not only to learn specific curriculum content but also to acquire a public health point of view. We have also encouraged a considerable amount of interaction, informally as well as formally, with the public health students of other specialties, so as to promote a "we feeling." In this we have been greatly helped by the fact that at Harvard many of the public health courses are taught in seminars and small tutorial groups and through the medium of team projects in which the students collaborate over several weeks or months in carrying out specific learning exercises.

Before ending these introductory remarks I would like to refer to one other technical problem. Education in community mental health is at present made difficult because no generally acceptable systematic body of knowledge has as yet been developed which satisfactorily encompasses the subject. Even if we narrow the field to the prevention of mental disorder, it cannot be said that we are today very advanced in being able to conceptualize the theoretical framework or the practical methodology upon which fruitful work may be based. If we wish to educate students rather than to train technicians, we must make a special effort, even at this early stage, to put down on paper in quite explicit form the development of our theoretical and practical thinking. We must force ourselves to be as scientifically rigorous as possible; yet we must face the realization that our practice cannot wait for the orderly and slow development of

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<sup>1</sup> This does not imply the advocacy of a new profession of community mental health to supersede the professions of psychiatry, psychology, social work, nursing, etc., but rather the advocacy of a new specialized professional orientation to be added to the basic disciplines, that is, to lead to the development of *community mental health oriented* psychiatrists, psychologists, social workers, nurses, etc.

proved knowledge, and for a long time to come much of it must be based on hunches backed by evidence of a flimsy nature, and even upon artistic intuition. To make such matters explicit demands courage and scientific honesty, but it is a challenge we must face and share with our students.

Our experience at Harvard during the last five years has convinced us that it is already possible to develop a reasonably consistent approach to the problems of preventing mental disorder. We freely admit that many of our concepts are hazy and that the pattern of our system is not only not stable but is changing continually in line with our widening experience. However tentative many of our formulations may be, we do nevertheless believe that we can nowadays define explicitly sufficient of our subject so that it makes sense to us, to our students and to at least our friendly critics. Upon this developing body of theoretical and practical formulations our educational program is based.

#### OUTLINE OF PROGRAM

The program in its current form offers a 1- to 3-year course to psychiatrists who have completed their specialty training; to psychologists with some years' experience after the Ph.D.; and to senior, well-qualified social workers. Students are admitted for one, two or three years at the level of the program in keeping with their previous training and experience in public health and community mental health. The emphasis in the program so far has been placed on the first-year course, which leads to a master's degree in public health—either the Master of Public Health or the Master of Science in Hygiene with mental health as the area of major concentration. Approximately half to two-thirds of the student's time during the academic year is devoted to the study of traditional pub-

lic health subjects, and the remainder is spent on theoretical and practical exercises in the mental health field. During the last five years 18 students have taken this course, and 2 have been accepted for the coming year.

The second- and third-year courses take the form of a residency program at one or more of the field stations of the mental health section. In the field station the student undertakes increasing responsibility, under supervision, for theoretical or practical work in research or service within the framework of its ongoing activities. In addition to collaborative work with the faculty team the student usually carries out one or more projects of his own and is responsible for writing reports on these. The residency program is designed to help fulfill the requirements of the doctoral program at the School of Public Health and candidates who choose to do so may work towards a Doctor of Public Health or a Doctor of Science in Hygiene degree. The residency program has been developed only during the last two years, and so far three students have completed one year, one student is currently in his second year, and two have been accepted for the first year of a doctoral program.

In addition to the master's and residency programs we offer opportunities for senior psychiatrists to come for three to six months as fellows to gain some understanding of the community mental health field. So far we have had two colleagues from overseas working with us in this category, by arrangement with the World Health Organization.

Our program also includes two other endeavors. We collaborate with the department of psychiatry of Harvard Medical School at the Massachusetts General Hospital in a 1-year training program in com-

munity mental health, which is offered to 3rd- or 4th-year psychiatric residents; to psychologists who are just about to get their Ph.D. or have recently graduated; and to social workers with several years of experience. This program is designed to give younger workers an opportunity to learn the rudiments of community mental health, and hopefully to interest some in continuing for more advanced training in this field.

The second of our supplementary programs plays a significant role in our general work. We have accepted responsibility for the in-service training in mental health consultation of selected members of staff of the division of mental hygiene of the Massachusetts Department of Mental Health. These include psychiatrists, clinical psychologists and psychiatric social workers, who attend regularly throughout the year one of two weekly seminars held at our central field station. During the last four years about 50 students have participated. Each worker attends seminars for two or three years, and during this period has an opportunity to learn the theories of community organization and mental health consultation and to participate actively in discussions of current consultation cases from his own or his colleagues' practice. In these seminars there is the possibility of a fruitful interchange between the university faculty members who are developing their systems of theory and practice on the basis of intensive studies in special field stations and the ordinary community mental health practitioners from the field. The seminar members operate from 16 regional mental health centers covering the whole of Massachusetts, and among them they encompass a wide variety of community experience. Insights which are developed at the university center are fed into the semi-

nar and can immediately be tried out on a wide scale under differing field conditions. The seminar members constantly feed back into the discussions the results of their endeavors, and this rich empirical experience serves to correct and modify the formulations of their teachers. Not infrequently insights have been developed during the seminar discussions which have illuminated and enriched intensive studies on mental health consultation conducted at the university center.

### FACULTY AND FACILITIES

The Harvard School of Public Health is one of six privately endowed institutions in the United States which are primarily devoted to graduate education in public health. The school operates as an independent unit of Harvard University in close association with the faculty of the College of Arts and Sciences, the Graduate School of Education, the Medical School, Dental School, and various Harvard hospitals. It provides instruction for a variety of students from this country and overseas who are seeking a career in one or more of the three principal areas of public health activities: teaching, research and administration. Its faculty is organized in the ten major departments of biostatistics, epidemiology, industrial hygiene, maternal and child health, microbiology, nutrition, physiology, public health practice, sanitary engineering and tropical public health. A number of interdepartmental courses are offered, and students may also take in other departments of Harvard University such courses as social sciences, public administration, business administration and medical sciences.

Our mental health section is located within the Department of Public Health Practice and has particularly close links also with the Department of Maternal and



Child Health. Our teaching staff includes 8 full-time members—3 psychiatrists, a clinical psychologist, a sociologist, an anthropologist, a social worker and a public health mental health nurse; and 10 part-time members—4 psychiatrists, 3 clinical psychologists, a sociologist, a social psychologist and a mental health administrator.

Our full-time staff is based in our principal field training station, the Harvard Family Guidance Center, which is situated close to the main buildings of the school in the Whittier Street Health Center of the Boston Health Department, with which our section maintains an active collaboration. The part-time members are based in a variety of institutions which carry out research and teaching and offer service in the mental health field and which are closely linked with the activities of the section, mainly through the provision of field training possibilities to our community mental health students and also to other students at the school.

All members of our staff participate in teaching theoretical and practical courses at the school, both within the mental health section and also as an integral part of the courses provided by the Departments of Public Health Practice, Maternal and Child Health, and Epidemiology. Their primary contribution to the education of students of community mental health lies, however, in their operation as staff members of the various field stations, where our specialty training is concentrated.

We believe that specialist training in community mental health is best carried out in centers where the student can increase his knowledge through active participation in selected phases of the ongoing work. To provide opportunities for students to have a varied and rich experience and to cater to a diversity of individual needs dependent on different background

experience and future career interests, we believe that a university center must be linked with a number of such field stations of different types. We have accordingly spent much time and effort over the last five years in arranging for the provision of such field training facilities, and today our task is almost completed. Each of our field stations is directed by one of our faculty members and includes on its staff other members of our faculty who are responsible for some particular project in which we are interested for training purposes. When one of our students is assigned to a field station, he works directly under the supervision of one of these faculty members, who maintains close and regular liaison with our core teaching group at the school. Although each of the field stations differs in important respects from the others, they all have in common the characteristics of placing major emphasis in their work on the community approach to preventive psychiatry in line with the prevailing philosophy of our mental health section, and they are all oriented towards the incorporation of research into their service activities.

I feel that the best way of giving you a concrete impression of this aspect of our program is to provide a brief description of the organization and activities of each of these field stations, which at present number six.

Our main field station, as mentioned previously, is the Whittier Street Family Guidance Center. This is directly administered by our section, with finances derived currently from the Commonwealth Fund and the National Institute of Mental Health. The unit has till now taken the form of a demonstration project to explore how a multidisciplinary team of mental health workers can establish and maintain collaborative working relationships with

the public health workers in a city health center with the object of studying fundamental aspects of the etiology of mental disorders which have a bearing on prevention, and of developing and evaluating techniques whereby this knowledge may be applied in practice by health and welfare workers as well as by mental health specialists. The main etiological studies so far have concentrated upon the response of families to the crisis of the birth of a premature baby. The health center deals with a population of about 100,000 living in a predominantly lower-class, racially mixed, congested part of Boston, and the families studied have been a stratified sample drawn from this area. It is envisaged that based upon the results of these and subsequent studies techniques of preventive intervention will be developed for helping families manage the crisis of premature birth and other hazardous events in ways which will be conducive to the mental health of their members.

Meanwhile, the main service provided by the center has been a consultation service to the public health nurses in the building to help them deal with the mental health problems encountered in their daily work. The processes involved in building up this working partnership are being studied, and methods are beginning to be worked out for evaluating the effect of these activities on the attitudes and performance of the nurses in contributing to the mental health of their ordinary patients. The demonstrated worth of this mental health consultation to the public health workers has already led to the recent establishment by the Boston Health Department of a city-wide program which is based upon the principles and methods developed in the Whitaker Street Center.

The Family Guidance Center has proved an ideal training station for our students.

They have participated in most phases of its activities, and many of them have made a very effective contribution to specific parts of its program while themselves benefiting from the opportunity to enlarge their theoretical and practical knowledge. Particularly beneficial has been the opportunity to experience some of the group dynamic problems of multidisciplinary team collaboration and to evaluate some of the ways of dealing with these, as well as to learn in concrete situations the kind of questions which can be effectively handled by different professional disciplines and the characteristic working approaches of each of these. This has proved the most effective opportunity for students to learn how to acquire and adapt the statistical and other research techniques of the social scientists in enlarging their own professional armamentarium.

Our plans for the future of this center, assuming we can obtain the necessary financial backing, are to continue the present line of development in the form of a permanent unit which will be called the Harvard Laboratory of Community Mental Health. This will provide a stable group of university workers who will continue the present integrated approach to pioneering service, research and training, which can be kept constantly geared to current needs in the community mental health field.

Our second field station is the Wellesley Human Relations Service. This is our oldest center and was started ten years ago by Erich Lindemann when he founded our section. It was staffed and administered directly by the section, with the financial support of the Grant Foundation during the first five years of its existence. Since then it has become a local community-administered unit, although it retains its link to our school by virtue of the fact

that its senior staff members hold appointments in our section. It is situated about seven miles from the school and is much used by our students. Its activities complement very nicely those of the Whittier Street center. The latter is focused on intensive collaboration with one single agency, the health department, and through this channel deals with an urban lower-class population. Wellesley's activities are integrated into all aspects of the community life of a suburban middle-class area which is small and compact enough so that it has been possible to build up relationships with most of its community agencies. Whereas the Whittier Street Center is fundamentally a research unit, Wellesley's activities are based upon preventive psychiatric service, the responsibility for which it has undertaken on behalf of the community. The main learning opportunities it affords our students are in the fields of practice—mental health consultation, community organization and preventive intervention—but as in all our field stations, each of these areas has from time to time research projects linked with them.

Our third field station is the South Shore Guidance Center at Quincy, Mass. This is a community mental health center administered by the Massachusetts Department of Mental Health in collaboration with a local voluntary organization of citizens, and financed partly from State funds, partly from local tax funds and partly through the Community Chest. It has developed from a long established child guidance clinic, the activities of which have been broadened to cater to the mental health needs of a mixed urban and rural population of 200,000, situated seven to ten miles from Boston. It has excellent collaborative relationships with the local courts, police and school systems, and

through these connections it has been successful in organizing two epidemiological research projects—one on the incidence and prevalence of acute and chronic emotional disorders among the children of the area, together with a study of preventive intervention techniques for dealing with the acute crisis situations identified in the study; and a second project to develop a psycho-bio-social classification system of juvenile delinquents, which will be related to prognosis and thus clarify problems of disposal.

The director and three of the senior staff members of the center are on our section faculty. Our students have made use of its facilities, particularly the research projects, and have obtained supervised experience in mental health consultation in one of its five affiliated school systems.

Our fourth field station is the head office of the division of mental hygiene of the Massachusetts Department of Mental Health, in Boston. The director and his two associates are members of our faculty, and they provide opportunities for our students to spend some time learning at first hand some of the problems of administration and community organization at the state level.

We are at present exploring the possibility of supplementing these opportunities for learning community mental health administration by making use of appropriate facilities in California. This summer one of our students, a psychiatrist from Portugal, spent two months in California under the supervision of Dr. Schwartz and Dr. Hume learning something about the state's administrative problems and how they are being handled. It may be that through the good offices of these state officials, we shall shortly be able to add California to our list of field stations.

Our fifth field station is the Community



Mental Health Service of the department of psychiatry at the Massachusetts General Hospital. This deals with the problems of the neighborhood immediately surrounding the hospital, and its activities are currently focused mainly on a study of the mental health effects of urban relocation. It happens that the major portion of the population of that area is in the process of being moved to other parts of the city in a slum clearance program. We have organized a research project under the joint direction of Erich Lindemann and me, and financed by the National Institute of Mental Health, to study the psychological effects of this community crisis. Some of our students have already made valuable use of the learning opportunities provided by this project.

Our last field station is the Greater Lawrence Guidance Center. This is a community mental health center administered by the state in partnership with a local citizens' voluntary organization. It caters to the needs of five adjoining towns with an aggregate population of 100,000 which are situated about 26 miles from Boston. Its special characteristics derive from the fact that it lies so far away from Boston, that its citizens turn much more for service to local agencies than people living within easier reach of the metropolis, and from the associated fact that its core staff is composed of local residents who are themselves, as individuals, well integrated into their community. The latter factor provides opportunities for rich insights into the life of the community and also leads to special personal problems for staff members who have some interesting difficulties in differentiating their professional and private roles. This center is linked to Harvard by the director's being a member of the faculty of our

section and by my acting as its psychiatric consultant. It is too far removed from our school for more than occasional visits by our students, but its main usefulness as a learning opportunity lies in the fact that once every two weeks its entire professional staff comes into Boston for a 2-hour consultation session with me at the Whittier Street Center. Our students are invited to these sessions, and since the meetings are organized to deal with any problem currently arousing staff concern an opportunity is thus provided not only for our students to observe consultant and consultee techniques but also for them to obtain a firsthand view of a wide variety of the problems which beset the practitioner in the community mental health field. Like the in-service training sessions for the state workers, these meetings help to counteract any "ivory tower" tendencies of our faculty, and they help to keep us and our students in touch with the facts of life.

#### THE CURRICULUM OF THE FIRST-YEAR COURSE

Until this year our community mental health students were about equally divided as to whether they sought a M.P.H. or S.M. Hy. degree at the end of the academic year. The regulations at Harvard have now been changed to assure that students working for the M.P.H. degree obtain a more comprehensive and deeper understanding of general public health subjects than in the past. Twenty-five out of the 40 credit units for the degree are now to be obtained from required courses covering the whole field of public health theory and practice. The scheduling of these courses is such that our students would have difficulty in including their studies in mental health and immediately relevant

public health subjects. It is therefore likely that from now on our students will prefer to take the S.M. Hy. degree, which our school has specifically designed for candidates who wish to specialize in a specific category of public health theory or practice. This program offers a very flexible curriculum which can be tailored to meet individual requirements, and has only one required course.

The fundamental issue in planning the curriculum for a community mental health specialist at our school is to determine the most appropriate ratio of general public health and specific mental health subjects which must be fitted into a single academic year. Our experience so far leads us to the conclusion that although it is feasible to develop a community approach and a professional identity as a public health man within this space of time it is not possible to equip the student with sufficient community mental health skills so that on graduation he can expect to work at a high level as an independent specialist. We therefore see this first-year course as laying a foundation for specialization. Upon this foundation must subsequently be built the specialist structure, which can be acquired either through the formal training process we provide during the second- and third-year program or through an autodidactic or supervised learning experience in a suitable job situation.

It is difficult to describe briefly the curriculum of the first year because it has varied a good deal according to the needs of individual students, and it has been altering in line with changes in our thinking and with the developing educational policies of our school. I am the faculty adviser for each of our community mental health students, and perhaps an appropriate way to give you a concrete idea of an

average curriculum would be to envisage the advice I will probably offer the two psychiatrists whose course I will be helping to plan during the coming year.

They will probably both elect to take the S.M. Hy. degree, and this will mean that their only required course will be biostatistics and epidemiology, an integrated course designed to present the fundamentals of the two disciplines essential to the investigation of problems of health and disease at a community level. Biostatistical techniques are taught with special reference to demography, and a small number of diseases are covered in detail by means of lectures, seminars and laboratory exercises to show the methods by which our present level of knowledge has been reached, and to illustrate the principles of epidemiology.

In addition, I will probably advise them to take the following four courses taught by my public health colleagues:

**Principles of Public Health Practice**—in which the principles of administrative organization, personnel management, financing of health services, and public health law are presented as the basis of public health administration.

**The Organization and Administration of Health Agencies**—in which the practical application of these principles is developed through problem-centered discussions and in which each student is assigned to a small group to study a broad and current public health problem with the help of a seminar leader and various health specialists.

**Factors in Health and Disease**—which covers essential aspects of economic geography and nutrition (for example, agricultural practices and their influence on public health) and the relation between

environment and health (the importance of natural hazards, climate, radiation, smog, etc.).

Principles Basic to the Practice of Maternal and Child Health—which includes attention to the physical, social and emotional characteristics and needs of mothers and children, the principles of planning and operating maternal and child health programs, and criteria and methods for evaluating them.

We have a well developed social science teaching program at our school, and from this I will advise the students to choose these courses:

The Human Community—a course which deals with demography, social and cultural characteristics of human populations, the organization and behavior of human communities and their relationship to the environment, providing a knowledge of human populations, interpersonal relationships and social organization in preparation for the study of public health.

Research Methods in Community Health—a problem-centered seminar course which covers such methods and techniques as research design, surveys, case and longitudinal studies, as well as relevant statistical techniques, methods of constructing and administering interviews, and other methods of data collection and analysis.

Health and Illness in Cross-Cultural Perspective—a course given jointly with Harvard Department of Social Relations in the form of seminar discussions of specific studies of a socio-medical nature by experts who have practiced or studied health problems in a variety of cultures.

To this list I will add a course which is presented by the department of epidemiology, and part of which I myself teach, called Ecology and Epidemiology of Chronic and Non-Infectious Diseases. This

course is concerned with the ecological study of such diseases and disabilities as mental disorders, accidents and metabolic, neoplastic and degenerative diseases. In addition, particular attention is paid to the diverse effects on health which appear to be connected with patterns of human experience in such areas as parent-child relationships, dietary practice or social class.

Over the academic year these courses add up to 32 credit units, and I envisage that our students will perhaps accept the idea of taking almost the complete list, possibly to a total of about 28 units. This will leave them with about 14 or 15 credit units to be devoted to mental health topics. In addition to the portion of the course on the Epidemiology of Non-Infectious Disease devoted to mental disorders, they will probably wish to take the other two mental health courses offered to their non-specialist colleagues—Group Dynamics and The Control of Mental Disorders. They will take these courses not so much because they will expect to learn much new content, but to participate with their public health student colleagues in a learning situation focused on mental health matters. This will allow them to watch critically how the material is presented and to consider and discuss how the class reacts to various topics and methods of presentation. In the past our students have learned a great deal from these observations and from subsequent discussions of the problems involved in communicating mental health content to non-specialists.

These discussions take place in a specialist mental health tutorial which I hold weekly for two hours throughout the year and which has proved to be the focal point of our specialist teaching. These meetings have been largely unstructured or else planned on an *ad hoc* basis according to



the current interests of the students or myself. They have provided an opportunity to integrate the concepts derived from the public health courses with our ideas on **community mental health** and to have problem-centered discussions which allow the development of a continuous thread of basic principles from which a coherently patterned philosophy gradually emerges in the minds of the group members. These discussions have dealt with questions as diverse as the relationship of religion and psychiatry, group dynamics problems of interdisciplinary collaboration, the advantages and disadvantages of separate state departments of mental health and public health, research strategy in the community field, the merits and demerits of supplementary private practice for the full-time community health worker, principles and techniques in establishing a new mental health unit in a health department, and so on.

In addition to their active participation in the discussions from week to week, students have been required to choose specific assignments during the year to prepare semi-formal presentations to the group after reviewing the literature and consulting documentary sources. These presentations have covered such topics as the public health aspects of drug addiction, comparison of New York and California community mental health legislation, changes in incidence and prevalence of mental disorders over time as indicated by census figures, etc.

The remainder of the specialist learning opportunities offered to the students is derived from their participation in the practical supervised exercises at the field stations and from the seminars on mental health consultation and community organization which we hold at the Whittier Street Center.

In the past it has been possible for the S.M. Hy. students to spend an average of ten hours a week throughout the academic year at one or more of the field stations. In addition, most students have spent two whole weeks full-time on field work between the semesters, and some students have spent two to three months full-time in the field after the academic year ends early in June.

The kind of exercises provided are specifically designed to cater to the students' individual interests and needs. All students are provided with an opportunity to learn the practice of mental health consultation in a school system or a health department under the supervision of an experienced consultant. In addition, each student chooses a major field work project for his year's work. These projects are circumscribed aspects of the work of one of the field stations and usually have a research aspect, in the supervision of which we make full use of the assistance of the social scientists on our team.

#### THE SECOND- AND THIRD-YEAR COURSES

Space does not permit me to do more than refer briefly to our residency program. Our advanced students spend little of their time on formally organized course work, although some of them have in the past taken courses at the school and elsewhere at Harvard. They are mainly occupied in working on research projects and in acquiring and consolidating the skills of mental health consultation, community organization and preventive intervention by operating for various periods in field stations of their choice.

#### FOLLOW-UP AND EVALUATION

We have made a point of constantly soliciting the reactions of our students to the

content and method of our instruction, and we have used their opinions to guide us in refining and modifying our program. With the help of a special grant from the National Institute of Mental Health we have also developed on active follow-up contact with our graduates, to learn the nature of the problems which face them in their jobs, and how far our educational program has fitted them to deal with these problems. During the coming year we hope to hold a 2-day conference which will be attended by most of our graduates and which we hope will lead to some constructive suggestions for further improvements in our program.

We offer a certain amount of continuing consultation to our graduates on their current work problems. In certain cases where occasional personal contact has been possible this has been very welcome and has helped to foster further professional

growth and development on the job and to counter the sense of isolation in men holding responsible key positions in which they are operating on their own and in which they are subjected to powerful and complicated field pressures. We believe that such follow-up consultation relationships are of value to both parties. If managed correctly, they prolong the benefit of the teacher-student relationship in a situation of lessening dependency and serve to consolidate the gains of the academic program. On the other side, they help the educator to remain constantly abreast of happenings in distant areas of the field so that he can keep his teaching program up-to-date. By facing him with examples of the inescapable complexities of community mental health practice they help preserve in him that humility which is the basic element of his role.

DAVID ABRAHAMSEN, M.D.

# Mental hygiene services in private schools

In 1950 a research project was started in the department of psychiatry at Columbia University to ascertain what kind of child guidance clinics and mental health facilities exist in public and private elementary and secondary schools in the United States. The preliminary results of the findings in public schools were published in 1955.<sup>1</sup>

We are giving here the highlights of our findings in private schools.

To ascertain the quantity and quality of child guidance clinics and mental health facilities in private schools (independent schools)<sup>2</sup> in the United States, 380 sets of questionnaires were used to acquire information from selected private schools<sup>3</sup> in each of the 48 states. In cases where the information on the questionnaire was incomplete, personal interviews with the

head of the school or its representative were usually undertaken.

The first purpose of the questionnaire was to obtain data about the number of children recognized as emotionally disturbed, socially delinquent or manifesting both emotional disturbances and delinquent behavior.

The second purpose was to assess the quantity and quality of the resources at present available for dealing with such

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Dr. Abrahamsen is a consultant to the New York State Department of Mental Hygiene and a visiting professor of the graduate faculty of the New School for Social Research.

<sup>1</sup> *Journal of Pediatrics*, 46(1, 1955), 107-18.

<sup>2</sup> Not all private schools are to be considered independent schools.

<sup>3</sup> Among these were some parochial schools.



personality problems in children, the concepts of mental hygiene in the schools, and the resources believed by school officials to be essential for helping children.

The third purpose was to develop a concrete program of child guidance clinics in private schools.

Of the private schools 32%, with 32,909 children, returned the questionnaires, which is somewhat lower than the 35% returned by the public schools.

### FINDINGS

The percentage of emotionally disturbed children in private schools ranges between 0 and 80. The range is greater than in the public schools, where the percentage of emotionally disturbed children ranges between 0.6 and 60. On the average, the percentage of emotionally disturbed children in the private schools is 11.7, while the percentage of such children in the public schools is 10.

In 57% of the private schools mental hygiene problems are not discussed in the classroom. In the public schools the corresponding figure is 80%.

✓ In 24% of the private schools mental hygiene personnel give lectures to the children. This takes place in only 20% of the public schools. It is noteworthy, though, that in both private and public schools less than half of the mental hygiene personnel are specialists (that is, psychiatrists, psychologists or psychiatric social workers). This indicates that about 90% of the private schools do not provide such

a service by trained mental hygiene personnel.

On the average the private schools reported that 66.6% of their need for both professional and non-professional mental hygiene staff<sup>4</sup> is met, while the public schools reported that only 18.4% of their need is met.

Thirty-six percent of the private schools do not have any mental hygiene services whatsoever available for emotionally disturbed children, while 17% of the public schools do not have these services available.

The reasons why 36% of the private schools do not have any mental hygiene services available are many:

- Thirty-eight schools say they refer emotionally disturbed children to private sources of help.
- Six refer emotionally disturbed children to university sources.
- One school feels the community is not ready.
- Another reports that many children of psychiatrists and doctors are in the school.
- Five schools say they have limited funds.
- Six feel that all their teachers are guidance workers.
- Two report they do not take care of mental health problems.
- Fifteen say they do not take any disturbed children.
- One parochial school said a mental health program could not help emotionally disturbed children.
- One school said it would be unnecessary and unwise to have mental health personnel in the school.
- Another said it did not wish to disturb the mental serenity of the pupils.

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<sup>4</sup> To clarify what is meant by professional and non-professional mental hygiene staff in this study, the former comprises the child guidance unit, the psychiatrist, the psychologist, the psychiatric social worker and the school social worker, while the latter comprises the counseling teacher, the school counselor, the guidance counselor and others.

- Another said it is not convenient to have mental hygiene personnel in the school.

While, generally speaking, the public schools (figured on the basis of 2,500,000 children) indicated that they have only one psychiatrist for every 50,000 children, one psychologist for every 11,000, one psychiatric social worker for every 38,500, the private schools (figured on the basis of 32,000 children) have one psychiatrist for every 2,500 children, one psychologist for every 950, and one psychiatric social worker for every 11,000.

The greatest number of emotionally disturbed children, 16% on the average, were found in schools having more than 100 and fewer than 300 pupils. About 13% of emotionally disturbed children were found in schools having more than 500 pupils, while only 3.6% were found in schools having between 400 and 500 children. If any conclusion can be drawn from these statistics, it is that the best private schools (that is, those having the least number of emotionally disturbed children) are those which have between 400 and 500 pupils. Such a conclusion is wrought with faults, however, since the level of mental hygiene in a school depends to a large extent upon other factors, such as how carefully screened the children are before admission, the emotional climate in the school, the recreational facilities available and, above all, the type of emotional relationship existing between the teachers and the children.

In studying mental hygiene personnel in private schools we find in the child guidance and psychiatric professions a pronounced disparity between available facilities and what the school authorities consider necessary to meet their needs. Although the disparity is not so pronounced for the other groups (psycholo-

gists, psychiatric social workers, counseling teachers, school counselors, guidance counselors and others), what exists definitely falls short of what is needed in all other areas except one, namely, the school social worker, where the need and the available personnel are exactly equal.

The most frequent category listed by private and public schools is the counseling teacher, though the work he carries out is rather undefined. This category is considered by many school administrators as a professional discipline on the same level as the disciplines of the psychiatric team. (As we know, the psychiatric team consists of a psychiatrist, a psychologist and a psychiatric social worker. Sometimes a school social worker is substituted for a psychiatric social worker.) As we found in public schools, many private schools use the counseling teacher as a mental health resource. As a matter of fact, these counseling teachers by and large have little or no training in psychodynamics or therapy techniques. Only where mental hygiene work is supervised by a part- or full-time psychiatrist have we found some counseling teachers who are qualified to help deal in a superficial way with emotionally disturbed children. It is unfortunate that the basic orientation of the counseling teachers is more or less that of the teacher-training schools, which frequently are more interested in academic achievement than in emotional growth.

It is interesting to note the relationship between the personnel needed and the personnel which actually exists in the private schools. Take the psychiatric team, for example, in this case also including school social workers. We find that three times as many child guidance units are needed as exist. The actual picture is even more dismal in that most of the

clinics do not fulfill the standards we have for a child guidance unit, which should consist of at least one part-time or full-time psychiatrist, one psychologist and one psychiatric social worker. Only in a few private schools throughout the United States do we find child guidance units which satisfy the regulation standards.

The need for school psychiatrists is almost three times as much as the supply. Psychologists are employed in a ratio closer to their need than are psychiatrists. Psychiatric social workers are required in a ratio of 5:3 above what the private schools have at present. There exist as many school social workers as are needed.

In comparing the public and private school systems in the United States as to the expressed need for different types of mental hygiene personnel, we see that there exists a greater discrepancy between needed and existing facilities in the public schools than in the private schools. Relatively the greatest need is for child guidance units, psychiatrists, psychiatric social workers and school social workers, while the need is fairly well-satisfied for psychologists, at least in the private schools. The relatively lower need for psychologists above and beyond the present supply in schools can be explained by the fact that in the past they played a much greater role in the educational system than did the other groups.

The public schools report a greater need, above and beyond what they already have, for more child guidance units, psychiatrists, psychologists and psychiatric social workers, relatively speaking, than do the private schools. The only need which is fully met is the one for school social workers in the private schools. The reason this need is not filled in the public school system may very well be that these schools usually would rather employ psychiatric

social workers than school social workers, the role of the latter generally being less clearly defined. On the other hand, private schools apparently would rather employ school social workers—a group not so psychologically or dynamically oriented as are psychiatric social workers and generally requiring lower salaries.

Now let us note the percentage of need for mental hygiene personnel now being met in public and private schools. The sampling of public schools was taken from a large city in the East which recognizes the emotional well-being of the child as an important factor in furthering the educational process. When we compare the "professional" clinicians of the mental hygiene staff in private and public schools, we find that only 14.6% of the need for psychiatrists and psychological personnel is filled in the public schools, while in private schools 57.5% is filled. Where the non-clinicians of the mental hygiene staff are concerned, 22.2% of the need for personnel is satisfied in the public schools, while the private schools have 75.6% of their need supplied. When clinical and non-clinical staff members are combined, only 18.4% of the need for mental hygiene services is covered in public schools, while 66.6% is covered in private schools.

There are some private schools throughout the country, particularly in the East and West, that not only maintain high scholastic standards but also take care of the emotional and mental needs of their children to a large extent. These schools are very well aware of emotional disturbances in their pupils and offer psychiatric help. One such school in the Northeast which has about 400 pupils wrote the following:

"Head of school has had considerable training in mental health problems. As a result, girls are referred to psychiatrists for a survey of their needs for reasons that may



seem trivial to some schools. The Delaware program is used in two classes. A course in human relations under the direction of a man in that department at X University is given our seniors. A number of our teachers are being analyzed. We have a group of eight teachers in a course in group dynamics under the leadership of a psychiatrist. The X Association for Mental Hygiene held a 1-day institute at this school in September. In other words, our school has, I hope, one of the outstanding programs in this field of mental health."

One private school with an enrollment of between 200 and 300 pupils on the West Coast states that 40% of its children are emotionally disturbed. This school is indeed aware of the emotional problems of its pupils. Its comments follow:

"We send children to psychiatrists chosen by parents, but we should like to have one full-time psychiatrist and one psychologist on our staff. Although we do not have any seriously disturbed children, we still need expert counsel for many children and a thorough psychological study of each one. We have a thorough testing program; we send many children to psychiatrists for diagnosis and therapy, but we do not have these highly trained experts on our staff. We wish very much that we did have that guidance. Some day we hope that will be possible. Then, perhaps, we might help to meet the increasing need that is pressing in upon us by taking in more children who need special help."

One private school was very frank in its answer to us when we asked how many children have difficulties recognized to be of an emotional nature. The school's reply was: "One hundred percent (of a normal nature) at one time or another, varying in seriousness and in length of

duration." Although this school recognizes that within normal limits all children have emotional problems, even from its frank answer it is difficult to see who decides the degree of seriousness of the emotional conditions of the pupils.

There are many private schools with very good reputations which are concerned about marks to a high degree, while the emotional equilibrium of the pupils seems secondary. Many private schools were more evasive in their attitudes and in their replies than were the public schools. It was obvious that some of the former disregarded the children's emotional and delinquent problems as if they did not exist. Even when there was strong evidence to the contrary, some of these schools denied they had children who were emotionally disturbed and delinquent or just emotionally disturbed. One receives the impression that most of the private schools appeared reluctant to indicate a need for additional mental hygiene personnel. Instead, they all stated they needed only as many as they had at the present time.

One basic reason for this is that they cannot afford, being constantly and completely dependent upon private funds, to expose whatever weaknesses they may have to the public. For that reason also some private schools have stringent admission rules. Some schools (15 in all) do not admit children who show signs of emotional disturbances. Other private schools are quite liberal in their admission policies. Some even seem to like to accept pupils with personality problems. This is particularly true of private schools located in or near big cities, where psychiatric help is more available than in rural areas.

Although the figures indicate that in many spheres the private schools do not seem to need much more mental hygiene personnel than they have at present in

their schools, further studies of our statistics and follow-up information indicate that there is a greater need than they seem to admit. The exact responses to our questionnaires by the heads of the private schools were tabulated, and where there seemed to be a discrepancy with other data we asked for further information. When this information was given, it frequently turned out that the private schools did not seem to have as much mental hygiene personnel or as many facilities available as originally indicated.

Statistics, however, good as they may be, are inadequate when it comes to depicting the human side of mental hygiene problems in the schools. Many private schools expressed a great deal of interest in our research and asked for help, while others showed a lack of understanding of the situation and even indifference to our inquiries.

For instance, to our question as to whether there are any psychiatric services available one school in the Northeast commented: "We do not wish to disturb the mental serenity of our pupils by suggesting psychiatric problems. We do not enroll pupils who are definite psychiatric problems." When asked how many parents are interviewed about the children's emotional problems, this same school answered: "We discuss the children's condition with all parents whenever there is an opportunity, whether they are normal or otherwise."

A small private school in the Southwest answered the question of whether psychiatric services are available as follows: "We do not take psychiatric cases knowingly. So very few of our children have such a difficulty, and then it is not great." The same school reported that it needed and had a psychiatrist, a psychologist and a counseling teacher for the children. In

view of the statements that the school does not knowingly take on any psychiatric cases and that few of its children have psychiatric difficulties, it seems rather encouraging that this school has as much help as it does—unless, of course, it is underestimating its students' needs.

One school in the East states that it does not need any psychiatric advice, although it admits having some children who are emotionally disturbed. On the other hand, a school in the Northwest which has between 100 and 200 students writes: "... while we do not have any person on the faculty whose position is dedicated specifically to mental health problems, we work very closely with a regular psychiatrist, who is especially able in his treatment of emotional problems." The letter goes on to state that the school has had some students who needed help beyond what could be offered by the school and also some who were "beyond our scope." They were sent to a school able to handle them.

Another school in the Northwest with an enrollment of 200 boys writes:

"We rarely have a delinquent boy in school, but, if course, we have students with emotional difficulties. These difficulties stem from adolescence, from poor home environments, or from failure to adjust socially to the school community. While we acknowledge the importance of solving these problems and of realizing the effect they may have upon a boy's ability to make the most of his youthful opportunities, we nevertheless will rely largely upon the counsel and advice of our teachers to help a boy solve his personal and emotional difficulties. There are so many opportunities for a teacher to discuss with an individual boy any special problems which he may be facing that we have come to feel that in the vast majority of cases our method is an effective one. . . . It is important to

point out that we do not hesitate to seek psychiatric advice from outside the school whenever it is clear that we are not helping a particular boy to meet his problems successfully . . .

"Considerable attention is given to religious education and to Christian worship. We have on occasions visiting preachers who are available for counseling purposes. Recently we had just this experience and with the most fruitful kind of result; because he came in from the outside and was a man for whom they had respect, they talked to him individually and in considerable numbers."

Although this same school notes that it regularly invites competent psychiatrists and educational counselors, not only to talk with its teachers about mental health techniques but also to discuss some specific student, the school did not feel inclined to fill out a simple questionnaire.

One school from the Middle West writes: "Our teachers, being trained as religious teachers, and the preacher are adequate to handle our problems (mental health problems)."

Characteristic is what a large school in the Northeast which has between 400 and 500 students states:

"We don't discuss mental health problems, nor do we have any mental hygiene talks with our boys.

"With a large selective group we have no delinquencies nor boys who present any problems other than those common to adolescence. If, during the time they are here, a boy develops an emotional problem, Mr. X and I talk with the boy and if necessary later with a doctor and the parents. In general, however, the few cases that develop are those which Mr. X and I can handle."

We find a similar answer from another school which has about 350 pupils, one

with which we have been in touch repeatedly:

"We have no students who even approach delinquency but plenty who have emotional difficulties which require careful handling. Out of 350 pupils in the school there are four who show obvious and serious emotional difficulties and 19 who show danger signs to teachers, though they may not be recognized as such to parents. And there may be no cause for alarm if the girls can have the right help and treatment from teachers and companions."

Such a statement comes from a school which apparently has easy access to psychiatric and psychological help but which will rely upon its own teachers to solve problems which most decidedly belong to the province of the psychiatrist.

One recurring finding in our research on private schools is that practically none of them admits that it has any delinquent children (that is, children who are unduly absent or who are involved in stealing, lying or vandalism). Yet many practicing psychiatrists have pupils from private schools in treatment who have been involved in delinquent or antisocial activities. It is alarming that most private schools do not admit that some of their students have delinquency problems. When a child, for any number of reasons, should fail to become emotionally secure, a failure which may lead to emotional disturbances, with or without delinquency, his school can be one of the best instruments for the prevention of these manifestations. No school, however, can help the child or his parents unless the school itself is aware of what is going on in the child's mind.

One of the grievances the private schools have against psychiatrists in general is that they do not seem to have a sufficient amount of understanding of the school program. Thus a school on the Eastern



seaboard which has between 300 and 400 pupils from kindergarten to twelfth grade states:

"There are 30 children who present unusual or overemphasized conditions (emotional difficulties). Before undertaking individual pupils, we try to determine how big a load the appropriate class can take. We never have room for pronounced deviates. We also insist on psychiatric assistance for disturbed children. I suppose we undertake about five new problems each year. We have found several psychiatrists in X City who are extremely knowing and helpful to children from 4 to 18. We have found none with sufficient understanding of schools and of the potential of schools for mental health to be of important value in recasting our program and approaches." After minimizing what psychiatry could do regarding mental health in schools, the school goes on: "I think we are on the way to conviction that a psychiatrist could help very much in our faculty meetings and could possibly be of real value in helping administration and staff to promote individual mental and emotional health."

It is regrettable that so few psychiatrists have taken an active part in promoting mental health in education. Psychiatry, which primarily deals with the diagnosis and treatment of the mentally and emotionally disturbed, has been slow in applying its knowledge to the field of education. My own experiences, having dealt in particular with one aspect of mental and emotional disturbances—namely, anti-social tendencies—have led me to believe that one important possibility in preventing these phenomena is to use our armaments in the field of education.

On the other hand, psychiatry must be careful not to convert the school into a clinic. As one school on the Eastern seaboard states:

"I know our general approach has been very effective in many instances. I think we are making progress in learning new ways of doing many things. On the other hand, I feel it is important that we are always very much aware of the limitations of any school in the psychiatric rehabilitation of students. The school should remain, in my opinion, an educational institution and in no sense become a clinic. But I believe at the present time that we could use a somewhat larger staff without running the risk of developing into something other than an institution primarily devoted to education in the usual sense. But even an expensive independent school must balance its budget."

It must be stated that even if all the private schools wanted to employ the needed psychiatric help, they most probably could not do so, either because there is not enough trained psychiatric personnel or because of lack of funds. More important than this, though, is the need for schools, private and public, to learn to recognize emotional difficulties in children and to see to it that a program of diagnosis within the school and treatment outside the school be implemented. When educators become aware of mental hygiene principles they will realize that the classroom can be a place where children can test out their own ideas of group living and be encouraged to work out their problems. If they fail to recognize these principles, the school will be a place where emotional or mental disturbances develop freely, bringing forth emotional maladjustments and delinquencies.

It is not sufficient for any school, private or public, to be concerned only with teaching the three R's. As I have stated on page 267 in my book *Who Are the Guilty, A Study of Education and Crime*, it is now time for the schools to start thinking about

the fourth R, "relationships," that is, "emotional relationships." It is essential that teachers learn to understand the emotional attitudes of their children, and it is essential for the healthy growth of these children that they learn about themselves and their feelings toward their teachers and toward their classmates. The time will come when an integrated synthesis of the curriculum of the three R's with mental hygiene principles will be established so that both personality growth and the educational process can be developed simultaneously. If a school is to benefit pupil and teacher alike, it will have to see to it that principles of mental hygiene be woven into the pattern of the curriculum. Although this may sound idealistic, it still will have to be the aim.

Teachers must learn that mental health concerns itself with all aspects of human behavior. It is true that while psychiatrists can learn from collaborating closely with educators, so too educators can learn from close association with psychiatrists.

## SUMMARY

Relatively speaking, private schools show a greater number of emotionally disturbed children than do public schools, but the former have better access to psychiatric help, particularly because their children are of a higher economic status. With respect to mental hygiene facilities, public elementary and secondary schools do not compare favorably with private schools, though the latter too fall far short of their needs.

In many private schools the lack of mental health services results not only from a shortage of funds and psychiatric personnel but also from a rejection of the fact that all

children have emotional problems to some extent and that it is the task and duty of the educator to discover and prevent the development of emotional and mental problems that interfere with the learning process in the classroom and with the emotional well-being of the pupil.

A child learns best when he is emotionally happy. It is this happiness that every educator, whether he is in a private or a public school, has to further.

## ACKNOWLEDGMENTS

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## Social functioning of the multi-problem family

In recent years the term "multi-problem family" has come into ever more frequent use to designate a phenomenon known to welfare organizations all over the country: the seriously disorganized family.

To the best of our knowledge the term was first used in 1948 in the St. Paul family unit report study. This was an account of problems and services—economic need, social maladjustment, ill health and recreation—carried out by local agencies in collaboration with Community Research Associates, Inc. As used in this study, the

term referred to the presence of more than one of three problems in a family situation: economic dependency, social maladjustment and ill health.

As a term to designate a type of family which has long been a major concern to welfare agencies, the word "multi-problem" was sufficiently descriptive to identify readily the object it represented. As a theoretical and operational concept, however, it was in need of more precise definition.

The effort reported here to refine the concept of multi-problem family is part of an evaluation study undertaken by the research section of the Family Centered Project of St. Paul. A one-sentence characterization might label this a social work pilot project having the dual focus of developing methods of casework and processes

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Mr. Geismar is research associate for the Family Centered Project of the Greater St. Paul Community Chest and Council. His paper is a revised version of a report to the 21st Groves Conference on Marriage and the Family, held April 14-16, 1958 in Washington, D. C.



of community organization, both designed to help the seriously disorganized family. Organizationally the project is an alliance of seven local agencies, public and private, which with the financial aid of the Hill Family Foundation and under the auspices of the Greater St. Paul Community Chest and Council joined hands in providing treatment for the hard-to-reach, disorganized families with children in clear and present danger.

This paper will discuss only one of the objectives of our research: The search for a method of appraising the behavior of multi-problem families. The need to develop a clear basis for the multi-problem concept was at the root of the evaluation study.

## **SOCIAL FUNCTIONING AS A CONCEPT FOR EVALUATING THE TOTAL FAMILY**

The choice of method for evaluating families was indicated by the project's basic approach in serving them. Throughout treatment the family is viewed as an interacting group and the individual problems of members are seen and treated in their group context, that is, as affecting all the members of the family. Evaluation, it was felt, should likewise take account of the whole family rather than only of individuals or segments of the group.

The concept of social functioning was most appropriate for analyzing the behavior of the total family. Social functioning first of all was a concept which permitted us to relate the individual and collective behavior of family members to the tasks assigned to them, as it were, by society. This enabled us to evaluate family conduct on a scale of values which made measurement feasible to the extent that these "assigned tasks," known to the sociologist as role expectations, could be organized conceptually.

Secondly, family-centered casework had focused on the social functioning of the family, and the concept had served the social worker in the project as a basis for gathering data for his social diagnostic study of families.

The concept of social role offered itself as a natural correlate of social functioning. Role represents the functioning of an individual within the context of a given situation and in relation to certain social norms called role expectations. Social role thus provides the link between the individual and the social system, for the roles of a person define his functioning in a network of roles and with a set of role expectations, both of which are parts of that system.

The utility of the concept of social functioning in our effort to define the multi-problem family lay in the fact that the conceptual scheme discussed here made it possible to view the behavior of family members in relation to a set of problems with which the larger group—in our case the local community—is concerned. To make this relationship more specific there is need to explore whether it is possible to identify a universe of social functions which are "assigned" to the families the project is serving.

## **THE PATTERN OF SOCIAL FUNCTIONING OF THE DISORGANIZED FAMILY**

Prolonged experimentation—in collaboration with casework—with abstracting case records in terms of tentative categories of family functioning resulted in the establishment of a 9-category pattern which the caseworker found useful and which satisfied minimum criteria for statistical reliability. These will be referred to later on. Each category is composed of two to four subcategories, making a total of 26 subcategories of

functioning.<sup>1</sup> The 9-category pattern of social functioning comprises four areas—family relationships, child care and training, health practices, and household practices—which require role performance largely within the family group. Three areas of functioning—economic practices, social activities, and the use of community resources—refer to role-playing chiefly outside the family. An eighth area—called relationship to the family-centered worker—which likewise involves role performance outside the primary group, does not generally constitute one of the functions that are basic to the welfare of the American family. In the disorganized family under treatment, however, the relationship to the family-centered worker, who is in a primary helping position, becomes a major focus of family functioning.

All eight categories thus far enumerated represent an accounting of the manner in which socially “assigned” tasks—“assigned” or expected by the community—are carried out without major regard to who performs them. By contrast, a ninth category of functioning—individual behavior and adjustment—reflects the manner in which each family member performs his various social roles.

The 9-category pattern can hardly be considered a scheme which is adapted to any and all groups of families even in the urban American culture. Its theoretical and empirical basis is the socially disorganized family in a medium-sized community. Any categorization of functioning such as this must take full account of the focal areas in which family life is carried on. For a group of upper middle-class families, the category “political behavior” might well be such a

focal area in family life. For the disorganized family such behavior, though expressed through voting, union membership and so on was not found to be sufficiently prominent to merit analysis as a major category. Political behavior, when present, could be dealt with under “use of community resources” and “social activities.” “Relationship to the caseworker,” by contrast, would hardly constitute a major focus for analysis in the functioning pattern of the American middle-class family.

The 9-fold categorization of social functioning opened the way for characterizing problematic or multi-problematic functioning of the family in analytic terms. Before this could be done, however, there was need to mark off the dimensions of functioning or malfunctioning in each of the nine categories designated. This proved to be the least objective and thus most problematic aspect of our evaluation procedure, because any attempt to mark out specific levels of adequacy of functioning in clearly defined areas of family functioning required the use of value judgments.

#### LEVELS OF SOCIAL FUNCTIONING

The social work discipline is no less guarded than the non-applied behavioral sciences in its use of value judgments in research. That which is inevitable in casework—the separate evaluation of the functioning of individual clients or client families—is viewed with serious reservations and apprehension when it is used in connection with groups of clients. It is suggested here that the standards of evaluation, which are implicit in the work with each individual family and determine such activities as case opening and closing, referrals and so on, form a basis for evaluating the functioning of groups of clients.

Family-centered and protective casework

<sup>1</sup> For example, the category “economic functioning” was subdivided into 1) source and adequacy of income, 2) job situation, and 3) money management.

with disorganized families justifies its intrusion into the affairs of resistive families because they are of real concern to the community, particularly in the way their children's welfare is being directly threatened. This factor of community concern, which is most clearly expressed in the violation of laws and ordinances (thus giving the community a clear right to step in), represents the content for a set of beginning definitions, as it were, in an evaluation of family functioning.

Community concern may be seen to comprise two related dimensions: the welfare of the family and the welfare of the entire community. These two are likely to coincide in the long run to the extent that the welfare of the family is ultimately linked with the welfare of the community. From a short-range point of view the two are not always in complete harmony, and professional casework is charged with the task of reconciling them.

To utilize the concept of community concern in evaluation, we had translated it into terms useful as bench marks in each of the nine categories of social functioning. Casework and research agreed that the construct "minimum level of functioning" or "marginal functioning" could serve as a central anchor point of a social functioning continuum with the extremes designated as adequate and inadequate functioning.

The concept of marginal functioning implies behavior in keeping with the minimum requirements for the protection of the community. These requirements include the maintenance of physical and mental health, the preservation of a degree of family unity which will provide a basis for socializing the children, the prevention of physical and emotional neglect of the young, of law violations, and of the family's otherwise becoming an undue burden upon the community. "Marginal func-

tioning" refers to behavior barely above the level at which the community has a right to step in.

On this same scale of values "inadequate functioning" refers to behavior which clearly entitles the community to intervene because laws are being violated, the welfare of the community is threatened, and the well-being of the family is seriously jeopardized.

The main difficulty arises in connection with an effort to define "adequate functioning." It has been difficult to spell out definitions of adequate behavior in terms more positive than "the absence of law violations" and "functioning which is not inimical to the healthy physical and emotional development of family members especially the children." The danger in defining levels of adequate functioning is that of imposing the standards of middle-class culture. Nevertheless, our early attempts to define adequate functioning suggest that the caseworkers have, through their working identification and experience, acquired a more realistic set of expectations.

An illustration of the application of the three levels of functioning to "parent-child relationship," one of the four subcategories under "family relationships" might help clarify the nature of the task facing us in quantifying family functioning.

## INADEQUATE FUNCTIONING

No affection shown between parents and children; great indifference or marked rejection of children or cruel treatment accorded to them; no respect shown for one another; no approval, recognition or encouragement shown to children. If parents show any concern at all, it takes the form of rank discrimination in favor of a few against the rest. Parent-child conflict extremely severe, being so serious as to constitute



neglect as legally defined or otherwise being a law violation.

### MARGINAL FUNCTIONING

Affection between parents and children intermittent or weak or obscured by conflict. Parent's anger unpredictable and unrelated to specific conduct of children; family members played off against each other; marked favoritism with no attempt to compensate disadvantaged children; little mutual respect or concern for each other. Parents and children in frequent conflict. Danger to children potential rather than actual.

### ADEQUATE FUNCTIONING

Affection shown between parents and children. Parents try always to be consistent in treatment of children. Children have sense of belonging, of emotional security. Children and parents show respect and mutual concern for each other. Parent-child conflict is minimal or restricted by consistent attention. Free communication and desire for harmony.

Our present scheme of quantitative evaluation utilizes the three levels of functioning as anchor points for a 7-point scale, with adequate and inadequate functioning representing the scale boundaries and marginal functioning the central scale position. To both sides of marginal functioning two additional scale points were designated whose content was not spelled out. These four scale positions indicate functioning slightly above or below the three defined anchor points. The continuum of social functioning then reads as follows: A plotting of a family's functioning by

Inadequate	Near inadequate	Sub-marginal	Marginal	Above marginal	Near adequate	Adequate
X	O	O	X	O	O	X

nine areas and 26 sub-areas yield what we called the family profile of social functioning.

### TESTING THE EVALUATION PROCEDURE

To test the reliability of this evaluation procedure we profiled the functioning at intake of 36 disorganized families receiving service by the Family Centered Project. These cases represented client families which had been opened in the project during 1954 and 1955 and had come up for review and evaluation by the casework supervisory staff between July 1956 and August 1957. Half of the cases were closed at the time of the case review; the other half remained open for further service. Every family had received no less than twelve months of intensive family-centered service. The average length of treatment was 29 months.

The 36 profiles were rated independently by three judges—two researchers and a caseworker supervisor.

They agreed (checked identical or adjacent points on the scale) on 83.4% of the items judged—32.5% were identical points, 50.9% were adjacent points. Only 3.1% of the ratings were three steps or half the scale range apart. These results were quite encouraging for they showed a reasonable reliability in judging by the social functioning scale is feasible.

The interrelationship among main categories of family functioning was tested by means of scale analysis. This test showed that the concept "social functioning of the family," as organized in this study, ap-

proximates a uni-dimensional scale,<sup>2</sup> the most frequently problematic items in the total pattern of functioning being "indi-

<sup>2</sup> Coefficient of reproducibility .75; coefficient of marginal reproducibility .48.

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vidual behavior and adjustment" and "child care and training." By contrast, "economic practices" and "relationship to the family-centered caseworker" were found to be least problematic in the functioning of the disorganized families.

Social functioning requiring role performance chiefly within the family was significantly correlated with functioning in relation to friends, neighbors, agencies, communal institutions, etc.<sup>3</sup> This finding would suggest that data on the families' relationship to the community, more readily available to the agencies than is information on intra-family functioning, might be developed as indices of family disorganization.

The present method of evaluation allows us to differentiate among degrees and kinds of multi-problem family functioning, thereby infusing the concept "multi-problem family" with more specific meaning than had generally been attached to it in the past.

## COMMENT

We have attempted here to report in brief on our efforts to set up a conceptual framework for defining and evaluating the functioning of the multi-problem family. The scheme is now being subjected to more extensive testing for reliability. Following this we intend to use it for an evaluation of the social functioning of the families which have been served in the project.

With this investment we have just begun to scratch the surface of research on the disorganized family. If we have succeeded here in sharpening our analytic focus and in pointing the way, for ourselves and for others, toward expanding and strengthening as yet meager theory about the social functioning of the multi-problem family, our efforts will have served the general purpose for which they were intended.

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<sup>3</sup> Chi square 22.28; 6 degrees of freedom; level of significance about .001.

# The community psychiatric service

A provisional blueprint of  
an integrated and comprehensive service  
based on the community and  
embracing rehabilitation and after-care

The South African National Council for Mental Health is engaged in developing a blueprint of an integrated and comprehensive service based on the community and embracing rehabilitation and after-care. To date, a tentative scheme has been drawn up, based on the following premises:

The emotional impact and distress suffered by thousands of the population who are anxious and justifiably concerned about the welfare treatment and prospects of mentally afflicted relatives is so vast as to be incalculable, and is one of society's urgent concerns. With a view to providing some solution, the South African National Council for Mental Health established committees in 1955 to consider a blueprint for

future mental health services in South Africa.

In formulating this "blueprint for an Integrated Psychiatric Service" to improve mental health, preliminary cognisance must first be taken of the following ideas:

Planning must be creative. It is not enough to reshuffle existing facilities for treating mental illness so that a resynthesis of the old components is produced. Thinking needs to be radical, and must question the underlying attitudes relative to services provided for the mentally ill. To an extent therefore this blueprint projects an ideal for the future which if not immediately of practical application may at least show a path which could be followed. In this connection, reference is briefly made to some of the principles adopted by the WHO Expert Committee on Mental Health.

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Dr. Moross is medical superintendent of Tara Hospital in Johannesburg, South Africa.



In its second report the committee accepts the long-term principle of incorporating into public health work the promotion of mental health.

In its third report the WHO Committee deals with the place of the psychiatric hospital in the community, and concludes that, once the necessary minimum of "emergency psychiatric in-patient care" is provided, a great deal of attention should be devoted "to the development of extra-mural treatment facilities and other psychiatric facilities in the community." The committee deplores the fact that in the past too little attention had been given to the development of a real community mental health service in all parts of the world, and it recommends systematic employment of psychiatric hospital staff in extra-mural activities, of a therapeutic as well as of a preventive and educational nature.

Modern methods of treatment have, in most cases, eliminated prolonged periods of custodial care. In other words, with advancing techniques in medicine, the next phase of psychiatric evolution has come; and it now becomes possible to treat these patients, many of whom had previously perforce been allowed to lie and wait for spontaneous improvement or increasing dementia and deterioration. The concepts of isolation and other traditional attitudes towards mental illness that grew up in earlier days, and which were calculated to deal with a situation as it obtained then, rather than as it is now, have not completely disappeared; nor, for the most part, have physical location and structure of the mental hospital, away from the community, or locked doors and high walls.

It is now apparent that the newest phase in psychiatry is a complete reversal of all this. Previously, where patients were taken out of the community, we now try to put them right back into it. We believe today

that mental illness should be dealt with and treated in this context—in the medium to which it arose, in relation to normal people and to the society in which the patient has always lived. For example, the period that a patient spends in hospital should be, not a retreat from the real world in which he broke down, but a model of it, as it were, that enables him to learn to deal with the problems that beset him in real life, in a controlled environment and with guidance and help. This example indicates how treatment and reintegration into the community can become one and the same thing.

In the third report of the WHO Expert Committee on Mental Health, in 1953, it is stated that large mental hospitals of the traditional type are not really suitable for carrying out such modern programmes of treatment; that everything should be done to discourage the building of more hospitals of this sort, inasmuch as the large mental hospital is liable to acquire an impersonal atmosphere. Furthermore, it recommends that such hospitals should be located in the natural population to be served, as the mental hospital remote from medical and population centres cannot properly serve its community. The need is for free interchange between patients, staff and society at all times.

It is a little-known fact that many mental patients can, with certain provisos, be cared for in their community, either in private homes or in some type of supervised accommodation. The provisos are (i) that the community must first accept this idea; (ii) that a psychiatric service can be taken into the homes and hostels, so that acute psychiatric illness can be taken care of immediately; and that those patients needing support and guidance can have it continuously from qualified staff.

Reputable authorities state that the number of psychiatric patients who are potential

public dangers and who need therefore to be handled in state mental hospitals is very low, no more than 5% to 10% of all patients. The others at present in mental hospitals all over the world, if given the services outlined in the blueprint, could be dealt with effectively within the community.

Furthermore, many of these mental patients are capable of at least limited employment whether in sheltered employment schemes or under the provisions of something like the Disabled Persons Employment Act of 1944 of the United Kingdom, although the introduction of such an act in South Africa would conceivably pose a number of problems. This employment would result in enormous saving to society.

One has only to know what is being done in Sweden, and particularly in Amsterdam, to recognize that these are not airy schemes but could, with careful planning, be put into actual practice.

Any scheme which will adequately cater for present-day needs has necessarily to examine critically the accepted and traditional ways of dealing with mental illness. Some of these have been rejected outright, such as isolation of the mentally ill, and have no place in our scheme; the rôle of the mental hospital is in process of change; other aspects depend on the accelerated evolution which cannot be long delayed owing to the increasing professional and public interest and pressure in these matters; the last group, however, where active and somewhat revolutionary changes are envisaged with emphasis on maximum treatment in the community, are fully accepted and incorporated in the blueprint.

The blueprint embraces many different agencies and institutions in the mental health field. It must be stated that these can and do exist only in larger, more developed, communities. Also that the avail-

able facilities will differ in other ways, from country to country, from urban to rural society, and so on.

Obviously, the application of such a scheme must allow for flexibility and adaptation. It is considered, however, that the underlying principles enumerated below should form the basis of any framework.

#### FUNDAMENTAL CONCEPTUAL FRAMEWORK

The vast bulk of the total endeavour with the mentally ill must be swung from the treatment and handling of established mental illness into the fields of promotive, preventive and early active treatment. This will involve a re-allocation of rôle to those institutions at present solely involved in the treatment of established illness.

Previously and at present, in most societies, mental illness in its various forms and with its manifold results tends to be taken care of by discrete units. These are often field and, at best, only partially interdependent. Integration of all agents in a comprehensive scheme, conceived and executed on a sufficiently large scale to really effectively tackle the vast problem of mental illness, is necessary. The keyword of this new organisation is therefore "integration"—integration at all levels and of all agencies in the field. Administration and control must be coordinated and planning centralised, and the needs and functions of individual agents in the scheme subordinated to its overall requirements.

The treatment of the mentally ill must increasingly be done in the community, and moved away from the traditional isolation methods. Reconsideration of the total situation unshackled by traditional thinking and with present-day needs in mind leads us to the conclusion that the emphasis is

wrongly placed, and it is the psychiatric service in the community that should have the permanent role, and the other the more subsidiary one.

Another accepted and permeating concept that needs to be dispelled, again having to do with "discrete working" is splitting off of function. Hallowed by usage and entrenched by its operation, the idea is that prevention, detection, treatment and rehabilitation take place largely in separate areas, or, at best, are functions of separate organisations. For example, treatment and rehabilitation in general terms are usually conceived of as sequential, one following the other. It is recognised in the most enlightened quarters, however, that not only is the one a function of the other, but more pertinently rehabilitation should commence simultaneously with treatment. Efforts to adjust the patient to an appropriate functional level in his community on discharge should not commence when his psychiatric problems have diminished, but his rehabilitation should in fact constitute part of his therapy from the day he enters hospital. Socialisation, group techniques, psychotherapy, participation in milieu therapy and like procedures are as much directed at dealing with underlying causes of mental illness as in helping to equip the patient to deal efficiently with his surroundings, work, home, interpersonal relations, etc.

#### DETAILS OF THE BLUEPRINT

Many of the details of the blueprint are also laid out in the report of the fifth meeting of the WHO Expert Committee on Mental Health held in 1956.

Fundamentally, the plan is based on the idea that instead of having one large mental hospital which must perforce deal with every type of case and class of mental disorder, there should be smaller regional

units, upon which the entire mental health programme will be based, and where intensive treatment will be given immediately to recoverable cases. Such small regional hospitals should be situated in the midst of the community and their aim should be rapid treatment and full-scale rehabilitation. Instead of being custodial in nature, the essential object of this regional mental health service would be early detection and treatment of mental disease, the prevention of chronicity and prevention of relapse. Its results would be a decreased need for mental hospital beds and custodial care.

In stressing the importance of such small psychiatric hospitals right in the community, it is not intended to imply that prevention in the mental health field must be based there exclusively. On the contrary, it is felt that other facilities should also be used and that, in some cases, they may be more effective than the psychiatric hospital.

Particularly, psychiatric out-patient departments and other ambulatory services undoubtedly have an outstanding significance. Experience has indeed shown that out-patient treatment is effective for many types of mental illness formerly thought to require in-patient care.

From the point of view of the health administration, out-patient arrangements are desirable because in-patient care is far more expensive; and it can be proved that the more out-patient facilities provided, the fewer hospital beds are needed. The out-patient clinics must be more than just consultation and treatment centres, however. One of their prime functions is as a centre from which numbers of clinical workers—doctors, nurses, social workers and health visitors—diverge into the community.

The psychiatric hospital service must be as "open" as possible. As pointed out in the



WHO fourth report, the legal formalities of admission and discharge should thus be reduced to a minimum.

To sum up, then, the central structure of this mental health service should be a relatively small, active, treatment unit which could be provided with the necessary out-patient facilities, and in some parts with mobile units and which, apart from its therapeutic duties, could also serve as a clearing house. Such a centre could exist as an independent unit having perhaps a day or a night hospital attached to it; it might be part of a general hospital; quite frequently it would be in close geographical or organisational contact with a long-stay unit destined to cater for the chronic cases.

As to the community integration of the service, no rigid pattern should be followed. Other medical and social organisations, both public and private, are often able to cope with these marginal problems, and it is therefore most important that they should be coordinated with the psychiatric service. Such organisations should include the clergy, educators, certain welfare societies and the voluntary mental health organisations which exist in most countries.

The blueprint also takes cognisance of the recommendations made by the Expert Committee on Mental Health of WHO relating to facilities for chronic patients.

The long-stay unit is a necessary complement of the central establishment with its predominant interest in active treatment and prevention. It is a serious mistake to entrust to it the main responsibility for the work to be carried out in all spheres of mental health. In this connection, it must be mentioned that in countries where it is customary to care for the mentally sick in their homes, it may be necessary to ensure that only frankly anti-social patients are detained in hospital.

Evidence from countries where "boarding out" and domiciliary care are the rule rather than the exception shows furthermore that these forms of treatment are both workable and effective. Although a wholesale discharge of chronic cases from the mental hospital is out of the question, it is certain that a good number of the patients who live at present in institutions could readily be placed in sheltered employment or cared for by their families with the help of social workers and voluntary organisations. Many cases will, nevertheless, need more or less permanent institutional care. These long-stay patients should certainly not be deprived of the benefits of active medical therapy. WHO statistics show that 10% to 15% of the number respond very well to systematic treatment and, although the improvement obtained will perhaps not be sufficient to make their return to the community possible, it will often make their lives in the institution freer and fuller.

Geriatric patients with mental illness make up a large chronic group occupying a substantial proportion of mental hospital beds. These elderly persons could well be cared for and receive adequate treatment in modified facilities at lower cost. How this can be accomplished is not immediately clear, but it is certain that special arrangements are necessary for them, for the most part outside mental hospitals, and that a community service based on a central clinic as indicated in the blueprint is feasible.

The foregoing is a presentation of the broad principles involved. May I now indicate some of the ways in which this could be implemented.

The community in an integrated psychiatric service is the area from which psychiatrically ill patients come and to which they should return. For purposes of

clarity the community is divided into three areas—home, school and work—but these are closely interrelated.

An integrated psychiatric service needs to be concerned with promotive, preventive, curative and rehabilitative mental health service; and with their integration into most of the existing socio-psychological and health services in the community. Causes of social disorganisation should be sought, and its symptoms (for example, alcoholism, delinquency, divorce, etc.) should be dealt with by multidisciplinary groups of persons.

To promote mental health in the "home" area, attention will need to be directed to factors such as:

- Preparation of young people for marriage.
- Study of genetics and heredity.
- Marriage guidance when factors arise which may endanger marriage.
- Training of obstetricians and midwives in the significance of emotional factors in child-bearing.
- Guidance for young parents faced with such problems as the birth of physically or mentally handicapped children; sharing the home with parents; adjustments when marriage partners have different cultural or religious backgrounds.

Effective prevention of mental illness is a community responsibility; it is associated with the control of factors causing social erosion; with a recognition by the community of the need to establish and expand facilities for improving the social climate and for preventing mental illness.

Trained personnel who have an entry to the homes of the people have unique opportunities for recognising the early signs of socio-psychological breakdown and need to know the facilities in the community

available to help. These persons are primarily midwives, public health and district nurses as well as social workers. The need for such workers to work as an integrated team and to know when and where to refer problems to other workers is apparent (for example, a midwife knowing the effects of rejection in an infant and becoming aware of such an attitude may realise that this is a marriage guidance problem and persuade the parents to accept such help).

An enlightened public demands the establishment and expansion of services such as antenatal and postnatal clinics, child guidance and marriage guidance clinics, community and play centres and mental health services. It is recognised that such services will make community living more worth while.

The home and the school areas are intimately interrelated.

Pre-school clinics and nursery schools are areas in which early detection can be made and early treatment of physical or psychological problems can be given in which the family is treated as a whole.

School clinics staffed by doctors, nurses and psychologists need to be available, special schools for retarded children, child guidance clinics for emotionally disturbed children, out-patient clinics and children's hospitals to meet the various physical and psychological needs.

The play and recreational needs of children especially in congested city areas can be met (for example, by closing certain streets to traffic during certain hours).

Square pegs need not be fitted into round holes where vocational guidance and juvenile employment agencies are available.

School and home have, nevertheless, many problems calling for study (for example, deprived children, overindulged children, children from institutions and delinquents).

An enlightened public in which parents, teachers, employees and health personnel work together on problems affecting children is needed. Home, school and work cannot be separated. For example, if both parents work, children may lack necessary supervision. Emotional problems at home affect the child at school and the man at work. The training of children in individual and social responsibility in the home and the school will affect their contribution to work and to society later. The use of facilities such as vocational guidance will help to direct people into the areas of work in which they are likely to be successful.

Well-adjusted people need to work; absenteeism is common in persons with neuroses; enlightened employers of labour are aware that increased production requires an awareness of the needs of workers as persons, not only as technicians. Workers such as personnel managers, industrial nurses and social workers can assist in this aspect, and a close liaison needs to be made with general hospitals, out-patient and psychiatric out-patient services, social welfare agencies and mental hospitals, to enable workers to receive early treatment and to be accepted back on discharge from hospital. Physically or mentally handicapped persons,

whether the condition is congenital or the result of injury or disease, may require special training, or retraining, or may need sheltered employment for a temporary or permanent period.

While it is possible for members of a community to agree to promotive and preventive mental health measures, it is equally important for them to recognise that, with the present limitations of knowledge, a proportion of the members of the community will develop mental illness; and this should be accepted and early treatment sought. Some patients will be treated as out-patients, day-patients or night patients and able to continue as members of the community; others will require more intensive treatment in neuroses or other special treatment units; others may need prolonged care and control in mental hospitals or other long-term treatment units. Many cases will recover or improve sufficiently to return to the community. The community may require training and assistance to accept and aid in the rehabilitation of such persons.

Much work remains to be done in connection with this blueprint which, at this stage, is provisional and is presented as a basis for discussion. It is hoped that the plan will be finalised by 1960.



# Poems

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## CLINICAL EVIDENCE

Let us forget now  
The diagnosis and the prognosis,  
The authorities, and their authorities  
Marshaled in the footnotes;  
The graphs, the charts . . . the curve of  
predictability.

We have reasoned deductively,  
Tested inductively;  
Now let us drop the burden of this—for see!  
The pulse leaps to the finger,  
The eye brightens,  
The patient lives.

—HAZEL KUNO

## THE UNCONSCIOUS

Did not the unknown exist  
before it was known?  
Did not the dark prevail  
before it was prone  
To arouse the thoughts and  
ken of men?

All that we know was before  
we knew  
And all that is not understood  
Still exists for evil or good.  
In regions deep  
Remain the latent, the buried, the heap,  
The residue, the generator from which we  
power  
To prove and disprove,  
to laugh and to flower.

—ARTHUR LERNER

## THE SCIENCE OF PSYCHOTHERAPY

It is to ravel a thread—one truth—  
Out of the multi-dyed, rich-woven fabric  
of Truth,  
And to follow that thread blind-hopefully  
Through the psyche's labyrinth turns.

It is to build a tight corral  
For taming a few of the soul's wild horses,  
Closing one's ears to the herd stampeding  
outside.

It is whatever can and must be defined  
To keep the healer's mind sane, his heart  
from breaking;

And to allow, sometimes, a slip from  
science:

Out-thrust of passion . . . compassion  
Which pierces and heals his patient.

—HAZEL KUNO

## NEUROTIC, DEFENSIVE

Indeed I'm amazed at your virtuosity!  
Blindfolded you walk a tight rope,  
Swinging your arms for balance.  
One false step, you cry,  
Would plunge you into a pit of destruction.  
While I, unblindfolded, see  
You walk just an inch above solid ground.  
Terror is terror.

I respect your painful balance.  
Yet must I think: How freely you might  
stride to your goal,  
How those swinging arms might embrace  
life.

—HAZEL KUNO

# Book Reviews

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## PSYCHOLOGY FOR LIVING

By Herbert Sorenson and  
Marguerite Malm

*New York, McGraw-Hill Book Co., 1957. 672 pp.*

This is the second edition of a book for high school students first published in 1948. The chapters have been completely rewritten or revised to incorporate suggestions from teachers who have used the first edition with their classes.

The work is divided into five parts: What personality is and how it is formed; developing and maintaining mental health; physical growth and learning; intelligence and thinking, and two major decisions of adolescents, namely, choosing a marriage partner and choosing an occupation. Each chapter is supplied with preview questions, a summary and review questions or problems. A teacher's manual and a series of objective test questions are also available.

Each chapter is filled with concrete illustrations drawn from everyday activities, numerous photographs and suggestions for correlated films. As an example of concrete material supplied in the discussion, we may cite the chapter on personality. This chapter contains a personality questionnaire, a self-report test and a card from the Rorschach ink-blot test in addition to numerous concrete examples of individual behavior.

When considering this book as a text for high school students, several characteristics assume importance. One is that the discussion seems to be rather disconnected from chapter to chapter. For example, in the early part of the book there is one chapter on habits, how they are formed and modified and the part they play in life. There is also a chapter on basic needs and satisfactions. But when we turn to such a

chapter as the one on making a successful marriage, in which one might expect to find a discussion showing how the basic needs are involved in this problem, there is no reference to the discussion in the earlier chapter. The background developed in the earlier part of the book is not used.

Secondly, there is a tendency to oversimplify complex problems. For example, on page 25 the question is raised: When is a personality good? This is answered in seven short lines: "If you are likable," "if you are honest," "if you are a responsible person," etc. There is no suggestion that this is an extremely complex question which man is still in the process of answering.

Similarly in the chapter on getting the most out of studies, the possible influence of seeing a use in what is being studied is mentioned but how "seeing the use" is related to basic purpose or goals is not elaborated. Most of the space is given to such items as schedule, lighting, taking notes, improving the mechanics of reading, learning to concentrate. The concern is with techniques and not with the underlying dynamics.

A third characteristic is closely related to the second. Much use is made of do's and don'ts and rules. The emphasis is on what to do or what not to do rather than on developing a method by which one works out what to do using the underlying dynamics of the person, the situation and the probable effects of alternative ways of behaving.

Thus, although the book is simply written and well illustrated, it would require a very capable teacher who could knit the parts together to help the student develop a method of approaching problems in behavior and development that can be

adapted to the variety of situations which one finds in life. Do's, don'ts, musts, shoulds and rules cannot be substituted for a functional method.—RALPH H. OJEMANN, Iowa Child Welfare Research Station.

## THE QUEST FOR IDENTITY

By Allen Wheelis

New York, W. W. Norton & Company, 1958. 250 pp.

The first half of the twentieth century has unfolded an incessant chain of dynamic events ranging from the most fearful and primitive to the most scientific. In turn, these events have challenged old ways of life and the very ego security which spelled out man's identification.

Dr. Wheelis subjects the relevance of psychoanalysis as it concerns the great enigma of our time—a quest for identity—to critical examination. With the decline of the superego and the undermining of many traditional values and adjusting habits, personal unrest and insecurity have become more marked. The individual finds himself searching for a lasting sense of identity. (Is not this what he has always done in one form or another?) The author strikes home the point that man cannot rekindle the identity of the past, for this was not lost but more or less outgrown. Thus, identity is something which must be created and earned. It cannot be sought for merely as a lost mine or landmark.

Psychotherapy can prove to be helpful if it is employed as a method of inquiry subject to amendment as the individual emotional problems change. If, however, it becomes laden with restraints of orthodoxy and dogma, the therapeutic process loses its effectiveness.

*The Quest for Identity* includes many

personal narratives, excellently treated and very readable. They portray the developing social character of the day and offer some measure of social change in the individual. It is refreshing to see a psychoanalyst not only write about social change but also about problems of value and vocational hazards of psychoanalysis.—ARTHUR LERNER, Los Angeles City College.

## IF YOU ADOPT A CHILD: A COMPLETE HANDBOOK FOR CHILDLESS COUPLES

By Carl and Helen Doss

New York, Henry Holt & Co., 1957. 368 pp.

Out of their personal experience and with deep understanding of those who want to adopt a child, the Reverend and Mrs. Doss, parents of 12 adopted children of mixed races, write about what is involved in adoption—for the child as well as for the adults. In addition, they have familiarized themselves with professional thinking and literature, which they use as the basis for their advice and suggestions.

The authors attempt to help those who are considering adoption to arrive at an honest answer as to whether they could be good parents for a child, by examining their expectations, their motives, the kind of persons they are, and what a child needs for his well-being and growth. For those who cannot or should not adopt, they present alternatives.

In telling how to go about adopting a child, they correct prevalent misconceptions about the number and kinds of children actually available, and about the practices of social agencies which it is now the mode to attack. They explain the reasons for agency requirements and procedures, and point out the protection and professional casework help offered by agencies.



They consider the legal aspects of adoption and review the laws and procedures in the various states. The improvement of adoption legislation and provision of adequately financed and staffed adoption agency services are seen as the responsibility of community groups.

For those who have already adopted, they discuss how to deal with normal problems of rearing children, as well as those inherent in adoption.

The appendix includes a comprehensive list of adoption agencies by state in the U.S.A. and Canada, with a digest of the laws of each state.

This handbook transmits a conviction that adoption is a means of personal fulfillment for those who have the capacity to experience the true satisfaction of parenthood—contributing to the well-being and development of another person. The authors know that almost any child deprived of his natural parents, regardless of his age or race, needs and can bring gratification to the mature adult who is able to give him love and care for his own sake.—ZITHA R. TURITZ, Child Welfare League of America.

## REMEDIAL READING, TEACHING AND TREATMENT

By Maurice D. Woolf and Jeanne A. Woolf  
*New York, McGraw-Hill Book Co., 1957. 424 pp.*

While this book is primarily concerned with the multiple causes of reading disability it also contains the philosophy and theory behind the remedial reading program. Techniques employed in diagnosing, counseling, instructing and evaluating are covered. Case histories and group procedures help make this volume more meaningful from a practical standpoint.

This combination of psychological understanding and skill provides remedial reading suggestions for programs covering various age and grade levels.

The reading process itself is at best a very complex phenomenon. When serious authors such as the Woolfs expend time and effort in creating *Remedial Reading*, educators and clinicians, to say nothing of countless youngsters in the classroom, are the beneficiaries.—ARTHUR LERNER, Los Angeles City College.

## 1957 DIRECTORY OF PSYCHOLOGICAL SERVICES

An approved list prepared by the  
American Board for Psychological Services  
*9827 Clayton Road, St. Louis, Mo., ABPS, 1957. 156 pp.*

This is a carefully prepared directory by a special group, all diplomates of the American Board of Examiners in Professional Psychology. It contains a small but selective list of individuals and agencies in the United States and Canada which offer psychological services, both clinical and industrial, to the public. Although only 115 services are mentioned, the directory also lists the diplomates of the American Board of Examiners in Professional Psychology under clinical, industrial, counseling and guidance headings.

The appendices contain a statement from the American Psychological Association on the background and importance of the American Board for Psychological Services, paragraphs explaining the organization and operation of the board, and an outline of the standards in professional psychology.

Agency information and referral services will find this directory useful as a guide when in need of qualified psychologists or

psychological services or the kind of information contained in the appendices. All individuals and services listed have been thoroughly investigated and have met ABPS standards.

Although this initial list does not include all psychological services in the U. S. and Canada, its preparation is to be commended for it is a step in the right direction. This directory has been greatly needed for a long time.—EMILY L. MARTIN, National Association for Mental Health.

## THE FAMILY AND MENTAL ILLNESS

By Samuel Southard

*Philadelphia, Westminster Press, 1957. 96 pp.*

A real depth of understanding and the kind of supportive approach that offers both wisdom and solace are the outstanding qualities of this excellent little book by Dr. Samuel Southard, professor of pastoral care at the Institute of Religion of the Texas Medical Center in Houston.

The volume's potential readership is broad and should include all who come in contact with the mentally ill. Physicians and clergymen, for instance, will find it of great assistance, but the book performs its most valuable service for the families of the mentally ill. The author realizes mental illness seldom affects just an individual; usually the distress and heartbreak it causes reach out to engulf a whole family. This recognition that mental illness is a crisis for all the members of a family is sensitively explored and provides the book's main emphasis.

Realization that one of its members is mentally ill can come with shattering impact upon a family. Frequently there is

resentment, and stubborn refusal to accept the facts. The author acknowledges these attitudes and discusses perceptively all of their emotional ramifications.

The problems attendant upon treatment—where to go, whom to turn to, what to do—are considered at length. There is a comprehensive discussion of referral procedures, the commitment process and the family's relationship to the psychiatrist handling the case. If hospitalization is required and the illness is complicated by absence, there may be added problems. In addition to the disruption of family life, the individual roles—such as nominal head of the house, breadwinner and homemaker—may change.

Further emphasis on mental illness as a family problem is brought out in a section that discusses treatment for the family too and where to find the various kinds of professional help that is needed to meet the situation. Encouragement also is given to the family to become involved in the total treatment program of the patient.

A minister himself, Dr. Southard considers the role of religion, as well as psychiatry, in helping both the patient and his family. Knowing this book to be a valuable one—which it assuredly is—Dr. Southard still suggests that no written word can be a complete substitute for personal discussion of these problems with a doctor, a clergyman or a close friend.—VICTOR BALABAN, Ed.D., National Association for Mental Health.

## THE PSYCHOLOGIC STUDY OF MAN

By John Money, Ph.D.

*Springfield, Ill., Charles C Thomas, 1957. 216 pp.*

This book has two aims: to present a "critical inspection of familiar axioms

and theories" in psychology and to make a contribution to theory, particularly in the field of psychotherapy.

The author's psychotherapeutic orientation is evident from the beginning in the sorts of problems presented and in the illustrations chosen. There is much of interest in this approach. Human verbal and non-verbal behavior is seen as "sign" or "signal" of what is transpiring within the person and as reporting upon happenings engendered by some source which may be internal to the person or distant in time. The emphasis upon these signs as information messages is in accord with other recent theorizing.

In approaching his first goal, that of critical inspection of the "axioms" of psychology, the author presents a discussion of the mind-body problem, of the distinction between "reality" and "illusion" and of the problem of heredity and environment. These, of course, are classical problems. This discussion loses much of its force, however, because the author proceeds as if he were unaware of the present state of psychological theory. It has been a long time since a naive dualism flourished in this field or since psychologists innocently assumed that what is "environmental" is eradicable and what is "hereditary" is not. One might also question this statement: "Ever since Freud announced his theoretical decisions about the reality principle as opposed to the pleasure principle, and about the function of the ego to test reality, it has been bad taste to ask philosophical questions about the usage of the concept of reality in psychological theory."

This book also presents an original theoretical formulation in which ego functioning is analyzed into spectatorship, mastery and control.—JAMES G. MILLER, M.D., University of Michigan.

## THE ELDEST CHILD

By Edith G. Neisser

New York, Harper & Brothers, 1957. 174 pp.

The author sets out in this monograph on the problems of the eldest child to place them in the cultural setting of present-day America. To give this setting meaning she first summarizes from a wealth of anthropological material the customs of other cultures, both current and past, as they relate to the treatment of the eldest. They vary from killing the first-born in some primitive cultures to granting them exclusive rights, as in societies where primogeniture is the prevailing custom. Some societies expect the eldest to be a priest; others expect him to be a learned man. Some expect him to assume responsibilities in connection with other members of the family; others expect him to be a sorcerer. This survey of the range of customs and myths in various cultures lays the groundwork for discussing the life of the eldest in our society today.

First consideration is given to the circumstances surrounding the creation of a family by the appearance of the first-born, to what having a child means to the parents in term of their own experiences as children. Following this chapter there is one devoted to the meaning of being the only child in the family, its rewards and its vicissitudes. While being the only one may have its satisfactions in attention, it may also have its difficulties in the many ways in which young parents are unprepared to meet the needs of their first child.

A chapter is devoted to what it means to be the eldest when a second child arrives in the family. Following is a chapter on the eldest in relationship to a number of brothers and sisters, and the many variations that may exist in the sex and age distribution of these siblings, as



well as energy and intelligence factors that may make for serious competition. One chapter is devoted to the subject of the taking of responsibility by the eldest child, a facet of growing up which faces all children but has particular significance for the eldest child. The author discusses the adaption of the eldest to his peer group and also to various special situations.

The material is well written in simple clear English with no professional jargon. Many concrete examples are given of the problems under discussion with many concrete suggestions about the way these might be handled. It is a book that might bring considerable help to young people learning to be parents of their first-born.—JAMES M. CUNNINGHAM, M.D., Child Guidance Center for Dayton and Montgomery County, Ohio.

## THE HANGOVER

By Benjamin Karpman, M.D.

Springfield, Ill., Charles C Thomas, 1937. 331 pp.

I have the pleasure to recommend this book wholeheartedly to anyone interested in the problem of alcoholism. Dr. Karpman demonstrates clearly that alcoholism is a symptom of a deeply-rooted psychoneurosis rather than a separate disease entity. His concept of the hangover as largely a psychological state, rather than a purely physical one, is well taken; the hangover is a neurotic reaction intensified by the toxic effects of alcohol. He is correct in postulating that the psychological reaction to a drinking bout is frequently more disabling and disturbing than the physical reaction.

Dr. Karpman formulates that the neuroses of alcoholics do not differ in structure from other neuroses. The strong feeling

of guilt that is part of every hangover is stressed, this guilt feeling is largely responsible for the accompanying depression. By studying the hangover one can gain full insight into the emotional life of the individual. In treatment one must treat the underlying neurosis rather than the symptom—the excessive and compulsive drinking.

The book contains 14 case histories. The case histories of the men are most interesting and stimulating and give the reader considerable insight into the psychodynamics of alcoholism. Those of the women, although interesting reading, largely omit the more personal and sexual life which, without doubt, must be closely interwoven with their drinking.

The book is unusually well illustrated, and well written, which adds to its readability. It is a most timely and informative work.—HARRY R. LIPTON, M.D., National Committee on Alcohol Hygiene, Atlanta.

## CRIMINOLOGY

By Donald R. Taft

New York, Macmillan Company, 1956. 3rd ed. 779 pp.

In the course of some forty years of psychiatry it has been my lot to review a number of books. I have never been quite happy about it. This reviewing is a very tricky business. Whether you realize it or not, you take upon yourself, ignorant or well-learned as you may be, to pass judgment on the work of a fellow being. It involves delicate value judgments. So who am I after all to review with any degree of competence the work of another man whose field is not as familiar to me as my own field? Generally, is a social scientist competent to review a book on psychiatry? Most psychiatrists will answer in

the negative. Is a psychiatrist competent to review a book on cultural anthropology? Why yes, will say most psychiatrists; but a cultural anthropologist will come back and say positively not, you have to have special training in the subject. It is therefore with some trepidation that this reviewer undertakes to review a book in another field, yet dealing with a subject that is close to his heart.

Sociology has always been a problem to the psychiatrist, especially one who is psychodynamically oriented. The differences between these two disciplines are tremendous and not to be slighted. Criminology is a branch of sociology and at present deals with many social factors that refer to the criminal; psychodynamic criminology, on the other hand, deals with the criminal as a particular individual. Whereas criminology discusses chiefly the effect of the external environment on criminals, psychodynamic criminology refers to factors that have a personal meaning to the individual criminal. Where the psychiatrist emphasizes the individual aspects, the criminologist is concerned with the physical, material and objective aspects. Where conventional criminology discusses things from the standpoint of environment external to the individual, criminal psychodynamics considers everything from the standpoint of the environment internal to the individual. In other words, conventional criminology treats criminals as groups and virtually ignores the criminal as an individual; in psychodynamic criminology, the criminal is the very essence of consideration.

Naturally with two such widely divergent approaches the results must inevitably be different. Criminology, as far as this individual is aware, has never been of help to the criminal. On the other hand, psychodynamic criminology, as far as this indi-

vidual is aware, forever tries to be of help to the criminal. Psychodynamic criminology within its framework has done everything in its power to help the criminal and has evolved a system of psychotherapeutics that can and has cured the individual criminal. Over and above that, even when the field approach touches on individual aspects, as when the criminologist studies the family, he studies the family only insofar as it contributes to the problem of crime as a whole but does not consider that the presence of the criminal in the family has already changed its viewpoint.

Criminologists posit the question as to whether criminology is a science and ruefully conclude that it has not yet reached that status. Criminology as yet is only an offshoot of sociology and as such pursues the method that has been a part of the general sociological approach. For years it has been influenced by other sciences and has borrowed liberally from the related sciences of biology, anthropology, psychology and so on. So that in a sense sociology has been generally a compilation of material gathered from other sources and put under one heading, with virtually very little material of its own.

It is clear from Dr. Taft's statements that to him a study is scientific only if it can use the experimental method. Along with many others, he carries the fallacious idea that observational investigation is not scientific, that only experimentation can allow one to enter the sanctum sanctorum of science. This, of course, is entirely erroneous. For thus viewed, astronomy could never be regarded as a science; whereas, as a matter of fact, it is one of the best organized scientific disciplines. Paleontology, geology and the many biological sciences such as ichthyology, entomology, ornithology and a host of other disciplines are surely scientific, yet the

nature of the material would positively preclude anything like experimental study, except in a purely secondary supportive way as material for physiology, for example.

While not denying the value of experimental research, one may safely state that its place is limited and that by far the greater mass of scientific data has been gathered through observation. One is not aware that Darwin performed any specific experiments in biology, and his theory of evolution was developed entirely through observation of available material. In medicine most of what is known about neuro-anatomy has been obtained through study of diseased neurological conditions. Where would knowledge of biochemistry be today without the clinician's contributions to diabetes and metabolism, to vitamins and hormones? Observation is merely the study of what one may term nature's own experiments.

All this is only to indicate that the approach of criminology is wrong because it starts with the wrong premise. This is a type of material which by its very nature cannot be studied experimentally; yet it can lend itself to good scientific study if one knows how to use observation carefully and how to correlate the material available. It is not that the material does not lend itself to scientific study, but that the persons who study it are not scientists. Social life does not run in a haphazard fashion, but is subject to definite laws. The determinism that follows Copernicus and Darwin is of the same nature as that of Marx and Freud.

The criminal has been viewed in terms of biology as a mutant or an exception that runs counter to the general gamut of accepted behavior. Anthropologically, criminology has tried to digest Lombroso's ill-fated concept of criminality as an expres-

sion of degeneracy, which, although definitely refuted by modern understanding, still finds its place in the various discussions on criminality. On the psychological side, it has tried to measure the intelligence level of various criminals, hoping to find therein some difference that will delimit the criminal from the general population.

All these attempts appear to have failed. The more dynamically oriented students no longer look upon the criminal as a mutant, a degenerate or an intellectual inferior. The one single approach yet left for the criminologist to pursue—namely, the individual dynamic approach—has hardly reached the criminologist, although some feeble attempts in that direction are being made. It has remained for the psychiatrists, more particularly those concerned with mental hygiene and the extramural behavior of children and adolescents, to hit upon the basic core of criminality in studying the various types of behavior deviations.

Of this, unfortunately, we get very little in the book under review. What Dr. Taft gives us is a good all-around, albeit stereotyped study of criminalistics. The textual material does not differ substantially from the material one sees in texts on criminology of the last fifty years. Statistics are there, of course, but one fails to see that any light on criminals has ever been thrown by this or that group of statistics. Does it mean anything that there are more crimes in the winter than in the summer; more murders on moonlit nights than on dark nights; and fewer second-story robberies on rainy days as compared with dry days? A discussion of the relations of crimes to economic conditions, of foreign-born *versus* native Americans, of racial factors, of regional crimes, of religion and crime is presented. Does all this help to understand



the genesis of crime? It does not. One might as well study statistically the number of tall and short men among criminals, or blue-eyed and dark-eyed men, only to come to the remarkable conclusion that the distribution is exactly the same as found in the general population. Rich people steal and poor people steal; educated people murder and ignorant people murder; and the clue to their criminality must be sought not in the economic conditions, nor in intelligence nor in any like factors, but in the roots of their personalities. Criminality is the expression of a life-long reaction, and although a particular crime may have apparently been committed impulsively, it has taken a lifetime to prepare for it.

Thus it is that as one trudges through these endless discussions of social factors, there does not emerge any significant understanding of the problem of criminality, and the chief reason is that criminality is treated as a mass reaction with no attempt to understand the individual problems involved. So one is confronted here, in a sense, with a work written very much like Hamlet without Hamlet in it. There is a lot about murder, but not a word about the individual murderer; a lot about theft and robbery but not a word about the individual thieves and robbers. The central dynamic factor in the entire problem of criminality—namely, the criminal as a person—is completely missing.

Dr. Taft's comments regarding the meaning of psychoanalysis in criminology are nothing to write home about. He quotes Dr. Horney: "Neuroses are the price humanity pays for cultural development." This, he says, is contrary to Freud as neu-

roses are held due, not merely to suppression of instinctive drives, but to "difficulties caused by the conflicting character of the demands which a culture imposes on its individuals." This strikes us as not understanding Freud at all or understanding him so narrowly that it loses its meaning. One wonders why Dr. Taft found it desirable to quote secondhand from Karen Horney when it is well known that instinct *versus* culture is one of the main tenets of Freud. Dr. Taft could have done just as well by going to original sources some fifteen years previously. Anticipating Horney (?), Freud says: "Civilization is the fruit of renunciation of instinctual satisfaction, and from each newcomer in turn exacts the same renunciation. Throughout the life of the individual there is a constant replacement of the external compulsion by the internal. The influences of civilization cause an ever-increasing transmutation of egoistic trends into altruistic and social ones, and this by an admixture of erotic elements."<sup>1</sup>

It is precisely here that Dr. Taft fails to understand the meaning of repression in the framework of our culture. If he could but understand that repression is not a static process but an ever-acting dynamic process, at work twenty-four hours a day, seven days a week, all the time, he would also realize that repression is rarely successful in the full sense of the word or we would have had a perfect civilization. All neuroses, without exception, may be said to be results of unsuccessful repression. Every now and then we have a break through the iron curtain of repression and then we have an acute neurotic or psychotic episode. Breakdowns are not the only evidences of unsuccessfully working repressions. Criminality, in point of fact, is the result of unsuccessful repression

<sup>1</sup> Sigmund Freud, *Collected Papers*. Vol. 4. London, Hogarth Press, 1948, 297.

which, breaking through the barriers, brings forth criminality in all its pristine form. When a paranoiac goes berserk and kills a group of people, what is it but breaking through of repression? When a man in a state of acute homosexual panic kills many people, what is it but breaking through of repression? When an alcoholic paranoiac having "suddenly" conceived, in a state of pathologic jealousy, that his wife is unfaithful to him, that the children are not his children, kills the entire family and then because of guilt kills himself, what is it but breaking through of repression? It is strange that Dr. Taft, having mentioned the problem of repression, failed to take advantage of this in his attempt to understand human behavior, particularly criminal behavior.

He also says "the neurotic, unlike the psychopath, is overcome by feelings of guilt. These may be extremely painful. On the whole, they seem more likely to drive him in the direction of mental disease than in the direction of crime." Here evidently Dr. Taft repeats a popular misconception that neurotics are not criminally inclined, but if one uses the term *neurosis* in a broader sense and the ramifications that go with it, it can be observed that neurotics are all too often inclined to crime. Are kleptomaniacs neurotics or psychopaths? Where is the psychiatrist who can draw the line between a kleptomaniac and a common thief? Who knows where murder from passion ends and murder for profit begins? Many psychiatrists that have anything to do with psychodynamics will immediately answer that kleptomaniacs, some pyromaniacs and dozens of other phases of neurosis are definitely criminal and at the same time definitely neurotic.

Eighty-five percent of criminals who

were involved in predatory crimes did not, on the surface at least, give any indication of kleptomania but on analysis turned out to be kleptomaniacs of a specific type. What is important on the whole is not the crime one commits but the motives that lead to the crime. If in the commission of a crime a man is motivated by his hostility against authority, he is just as much a neurotic and as much a criminal as any other criminal may be, even as compared to the psychopath.

Dr. Taft calls upon Lindner and on Arieff and Rotman as authorities. The present writer certainly would not call them authorities just because each one wrote several articles on the subject. Dr. Taft mentions none of the works of Maughs or Conn, who have written extensively on the subject. This does not sound like a careful review of the subject of psychotherapy, a subject which has undergone tremendous changes for the last twenty years—changes which Taft has failed to record.

As befits a recently published book—what with the American intelligentsia, both professional and non-professional, having been tremendously influenced by the modern dynamic psychological approach and its emphasis on personal factors and interpersonal relations—this one shows evidence on the part of the author of large acquaintance with the material available. The acquaintance, however, is of the purely armchair variety, and there is no evidence that the author has absorbed and utilized it for the purpose of the study. Freud is mentioned at least once, but no Freudian dynamics are applied; William Alanson White—not William Allen White, blessed be the shades of both these great men!—is mentioned three times, all in footnotes with no attempt to discuss his contributions. Yet he was the father of

criminal psychopathology in America, a pioneer in his own right whose influence still prevails as is evidenced by the contributions of his pupils. The book bristles with all sorts of modern references, but they are all mentioned in passing footnotes and produce nothing, for little of it finds its way into the text.

Criminology as a science is yet to come. It is quite certain, however, that it will never come from the academic criminologists who sit in their offices and from their high chairs think what criminality might be, or who study large numbers and want to extract some significance from the group. It will have to be written someday by a criminologist who is equally well oriented in dynamic psychology and who will follow the study of criminology through the person as Pope advised the study of mankind through man. Such a criminologist will have an intimate appreciation of the dynamics of human behavior with an emphasis on interpersonal relations. It is thus through many such studies of individual criminals that criminology may eventually come into its own.

Within the limits of its framework Dr. Taft has produced a worthwhile and inclusive study of the various social factors involved in criminality, and as such this book may be recommended for classes in sociology and criminology. The criticisms that have been made are essentially concerned with the approach to the subject and would apply equally well to Sutherland and Cressey, Ruth Cavan, Vedder and others. This book compares favorably with the works of these authors. The chapter on the Negro in crime is very sympathetically written. The wider implications of criminology, especially the comparison of crime and war, are discussed very suggestively.—BEN KARPMAN, M.D.,

Archives of Criminal Psychodynamics,  
Washington, D. C.

## THE ADOLESCENT VIEWS HIMSELF

By Ruth Strang

New York, McGraw-Hill Book Co., 1957. 581 pp.

Dr. Ruth Strang is a well-known educator and always writes with authority and erudition. In *The Adolescent Views Himself* she has covered, in a comprehensive fashion, a truly neglected area of adolescence: "the ways in which adolescents perceive themselves and their world."

This is a practical book directed mainly to teachers and based quite literally on material obtained from thousands of teenagers, supplemented by Dr. Strang's graduate students' observations of adolescents. The author has done an excellent job of describing the many ways in which young people see themselves in "the psychological, social and physical setting in which they are growing up." Dr. Strang does not lose sight of the facts that growth is a continuous process, that the adolescent is an individual, that the "typical" adolescent is a "newspaper stereotype" and a fallacy.

Dr. Strang deals with the many developmental areas of the adolescent. How the young person copes with growing up, with his physical and sexual maturing, with social and peer relations, with the demands of the outside world and the family, with the problem of scholastic or vocational future, with achieving a sense of personal identity and maturity in our society.

In view of the current interest in schools I read with particular interest the sections on scholastic success and failure. It is a chapter helpful to teachers but points up what I consider as diminishing the value of this book. The unconscious factors in motivation, the prime mover in



scholastic success, are only hinted at. And, in general, the unconscious factors in adolescent growth and development are given bare treatment.

Another small criticism is that although the book is very well and clearly written, it is rather heavy reading, as so many textbooks are. Maybe this is inevitable in such a fact-filled study.

This is an eminently practical, descriptive, valuable addition to the literature studying the adolescent. While of special value to teachers, it is of undoubted value to all disciplines working with young people.—JOSEPH R. TEICHER, M.D., Child Guidance Clinic of Los Angeles.

## THE LIFE AND WORK OF SIGMUND FREUD

1919-1939, The Last Phase

By Ernest Jones, M.D.

New York, Basic Books, 1957. 537 pp.

This book, the last of a trilogy, is divided into two parts—one a chronological record of events, the other a brief survey of Freud's contribution to various fields of thought. The author was a student and colleague of Freud, who had the advantage of shared experience in many areas and who undertook the work with passionate zeal, but for whom the close association and adulation of Freud inevitably created difficulties of perspective.

The book is a vast storehouse of data and inference. Many interpretations of Freud's reactions and thinking seem unsupported by the facts given and perhaps colored by the author's fantasy. To students of Freud the book is bound to have much interest, painting, as it does, a picture of the development and background of his thinking and of the psychoanalytic move-

ment in Europe. To the lay reader, however, the first part, at least, is bound to be tedious. Eventually (after a laborious effort in reading) a portrait of Freud emerges suggesting a man of great intellectual gift, of sensitivity and directness (best observed in his letters), endowed with exceptional vitality, dedicated to his cause, often provocative, ungracious and demanding, but frequently generous, remarkably perceptive, mellowing as success brought for him a position of unquestioned authority, and enduring the almost unbelievable torment of the last sixteen years of his life with truly heroic stoicism. (Appendix B, a documentation of surgical procedures for his fatal cancer conveys this last as nothing else could.)

Perhaps he was driven to bring order to the apparent chaos of human psychic development and structure, motivation and psychopathology in part at least as an attempt to understand and solve his own neurotic conflicts. However that may be, his need to understand, evident from his earliest years in his searching scrutiny of literature, philosophy, religion, enabled him to pierce the cultural blanket of repression and denial enveloping his late Victorian era, and to discover how man develops and maintains a "self." The great value of this book is its rich source material for future studies of Freud and his work.—NATALIE SHAINESS, M.D., New York City.

## THE MODERN BOOK OF MARRIAGE

By Lena Levine, M.D.

New York, Bartholomew House, 1957. 158 pp.

The subtitle of Dr. Levine's book, A Practical Guide to Marital Happiness, seems to describe its contents most accurately.

In the foreword by Dr. Abraham Stone the statement is made that "although many of the viewpoints expressed (in the book) are based on the dynamics of modern analytical psychiatry, the author has refrained from resorting to glib psychoanalytical phraseology." The reviewer certainly would agree with this statement by Dr. Stone that the language of this volume is indeed "simple and straightforward."

As might be expected, since Dr. Levine is a gynecologist, the material in her book is addressed to women and is written primarily for a girl's or woman's point of view regarding many facets of love, marriage, sex and the problems pertaining to these experiences.

This book is divided into seven chapters dealing with many of the problems of marriage as they might relate to a teenager's questions regarding dating, working wives, infertility, promiscuity, etc. and moving along to problems arising in the marriage relationship itself. These problems or questions range from a discussion of how to get along with in-laws to preparing the next generation for their own responsibilities in a marriage.

Dr. Levine writes with sympathy and understanding. Insofar as any written material can help people solve problems within a dynamic relationship, it seems as if her treatment of the subjects of love and marriage can tend to allay individual fears. An attempt is made to discuss in everyday language the possible reality causation of problems in marriage while at the same time the deep-seated personality factors which can tend to create problems within a marriage are not ignored.

Dr. Levine states in her preface: "There was a time when there was a large gap between the findings of experts and their use in helping people. This gap is being narrowed to a greater and greater extent. It is hoped that in a small way this book

will serve such a purpose." It is the opinion of this reviewer that this book fulfills the author's expectations.—MARJORIE R. LANDIS, D.S.W., Lehigh Valley Guidance Clinic, Allentown, Pa.

## GUIDES FOR SENTENCING

Edited by the Advisory Council of Judges  
*New York, Carnegie Press, 1957. 99 pp.*

*Guides for Sentencing* is a product of the Advisory Council of Judges established in 1953 as a permanent body by the National Probation and Parole Association. This council is composed of some of America's most distinguished jurists from federal, state and local courts. Their small but highly instructive book marks a point of transition in the development of the operations of probation.

The concept of probation has always had a nominal acceptance in principle by judges, but formerly in practice it did not lessen their task of rendering judgments or their anxieties. It remained for a matter of principle based beyond humanistic incentive alone to reach a level of satisfactory operational practice based upon a disciplined experiment from which predictions of a high order could be obtained. In former times, probation had a larger foundation of sentiment and "hunch"; today it is founded more upon an ordered procedure and controlled method. Today, in jurisdictions which provide adequately for it, the practice of pre-sentence investigation has brought forth a large body of significant guides for judgment. The "hunch" factor remains, and there is yet room for it in every case as an intuitive human element of decision which the experienced judge alone makes. That this point of transition has been reached is confirmed in the statement in the preface by Judge Bolitha J. Laws: "Only judges would have the temerity to

present such a guide to other judges." And the judges who would offer such a guide to other judges are the acknowledged leaders of the American judiciary. This transition in the evolution of probation is also a transition of justice itself in the sense that the practice of probation has brought to justice a means of judging both the offense and the offender within a unitary frame of reference of psychosociological science. Out of this has come an axiom that no one should be imprisoned until it is determined that he is not a fit subject for probation.

*Guides for Sentencing* contains the essentials clearly delineated in five short chapters: Criminal Justice: Objectives and Setting, Dispositions Available to the Court, The Pre-sentence Investigation and the Disposition, Factors Affecting the Disposition, and Selecting the Disposition. Noteworthy in the chapter on factors affecting the disposition is the reflection of an irresistible trend of thinking which takes into account the personality of the offender, the symbolic meaning of his offense, the transactional nature of the offender-victim interaction that oftentimes triggers the unlawful behavior. Implicit also is the larger acceptance of unconscious motivational factors of criminal behavior, of the repetition principle (neurotic element), the weighing of which guides prediction and corrective management.

The remaining third of the book is occupied by appendices containing descriptions of typical offenders: the alcoholic, the narcotic addict, the mental defective, the psychopathic personality and the sex offender. Suggested reading lists are appended to each description. Two excellent standard samples of pre-sentence investigation reports are supplied, one from the federal probation system and another from an unnamed county probationary agency.

Central to the operation of probation is the pre-sentence investigation. The ra-

tionale of the pre-sentence examination is the determination of three questions: (1) Is crime the way of life of the offender? (2) Is the offender changeable? (3) Will probationary measures effect the desired change? The quality of this investigation will spell the weakness or strength of a probationary system, in fact, of the operation of justice itself. California and Michigan require a pre-sentence report on every felon, Colorado in every case of felony in which the court has discretion as to the penalty. Connecticut and Rhode Island require such a report in every case in which the sentence is for a year or more. All cases require pre-sentence reports in New Jersey and in the United States District Courts except for those otherwise directed.

This is an authoritative handbook which comes from judges who need not have "... the temerity to present such a guide to other judges"; the temerity may be more appropriately assigned to those judges who disdain the use of such a guide. *Guides for Sentencing* should find a place on the desk of every trial judge upon whom, again in the words of Judge Laws, "The sentencing of the convicted offender demands . . . the best that he has in wisdom, knowledge and insight, as a jurist and a human being."—PHILIP Q. ROCHE, M.D., Conshohocken, Pa.

#### SOCIAL CLASS AND MENTAL ILLNESS: A COMMUNITY STUDY

By August B. Hollingshead, Ph.D.  
and Fredrick C. Redlich, M.D.

New York, John Wiley & Sons, 1958. 442 pp.

As our social order becomes more complex, and as the roles that members of our society are called upon to perform become



more intricate, greater reliance must be put on the personality and its integration rather than on the individual as a "hand." Thus, from a functional viewpoint the problem of mental illness is likely to become more "salient" in our society (and in other contemporary large scale industrial systems) than it was in more bucolic times. Mental illness in society thus resembles the exposed but undeveloped sheet of photographic paper which under the action of the developing bath (increased complexity, specialization and differentiation) acquires sharper and sharper features. And as the rate of complexity continues to mount, mental illness and its impact on society will become more and more strategic, and the problems that medicine and public health address themselves to will become, by contrast, more routine and less critical.

The task of coping with mental illness will require a multi-sided and multi-disciplined approach in which orthodox medicine and psychiatry will have to incorporate into themselves knowledge from several other branches of science. In the nineteenth century the physical sciences helped medicine solve many of its problems; in the twentieth medicine and psychiatry may well have to call on the services of the so-called behavioral sciences, since problems of behavior and personality will become more critical to society.

The book under review, the joint product of an interdisciplinary research team headed by a sociologist and a psychiatrist (the senior authors of the book) is an exciting step in this direction. Two topics which Americans, for a series of historical and cultural reasons, prefer to ignore are examined: mental illness and social class. They surmise that there is some connection between these two phenomena and they hypothesize, more specifically, that:

1. A significant relationship exists between

the prevalence of *treated* mental illness and the individual's position in the class structure.

2. Types of diagnosed psychiatric disorders are related to class structure.

3. Treatment depends on the class position of the individual being treated.

4. Social and psychodynamic factors in the development of psychiatric disorders are related to an individual's position in the class structure.

5. Social mobility is closely associated with the development of psychiatric difficulties.

The study was conducted in the New Haven community.

Hypotheses 4 and 5 are to be the subject of a companion volume by Jerome K. Myers and Bertram H. Roberts to be published shortly under the title *Social Class, Family Dynamics and Mental Illness*. From the viewpoint of this reviewer, hypotheses 2 and 3 are the best documented and constitute the real contribution of the volume.

In the nature of the case hypothesis 1 is the most difficult to handle since we have little information on the true prevalence and incidence of mental illness. The striking fact which the authors show, however, is the high prevalence of treated mental illness among the members of the lowest socio-economic group in the population (Class V). In this class the proportion of treated mental patients is more than twice the proportion of Class V persons in the total population. But more important is the fact that the lower the class of the individual, the poorer the treatment he receives (if he receives any). The reason for this is not exclusively an economic one although this factor is important. It is also a cultural one: differences in values and expectations between psychiatric personnel and lower-class patients make it difficult to

establish and maintain a therapeutic relationship. This implies the need for a change in techniques or the need to develop a new type of therapist.

It would be presumptuous to try to detail all the many fascinating and burning issues which the authors raise in their book, and which show how inadequate our handling of psychiatric patients is at the present time. The book is not only a substantive contribution to our knowledge of the relationship between social structure and personality, but it is also illustrative of the kind of cooperative research which may well blaze a trail on the new frontiers of mental illness and mental health. As such, it can be heartily recommended both to social scientists and mental health specialists.—MARK G. FIELD, Ph.D., Joint Commission on Mental Illness and Health.

## THE HANDICAPPED AND THEIR REHABILITATION

Edited by Harry A. Pattison, M.D.

Springfield, Ill., Charles C Thomas, 1957. 944 pp.

This wide collection of papers is written by 44 co-authors of acknowledged stature in their fields of work. Each chapter has considerable merit in its own right, including an exposition of the views of the author and affording the reader the opportunity to note the stage of development of the profession or area. If the reader can disregard the varying levels of writing and can skim and leaf liberally, he will find sections of interest and value.

The first part of the book is devoted to "foundations" but the two chapters are hardly broad enough to really fulfill the purposes of the sectional title. The second part of the book is devoted to disability groups. This major section includes some

of the best chapters, including one on general principles of psychiatry and psychotherapy by Edward A. Strecker. The third section, another major one, is devoted to professional disciplines and their functions in and contributions to rehabilitation. The last section is a catchall although some of the most important and best-written chapters are found therein. The last two sections show most clearly the great difficulty faced by an editor who tries to bring together so many authoritative writers, namely, unevenness in style, purpose and level. Chapters are written for as diverse an audience as employers, labor leaders, internists, psychologists, psychiatrists, plastic surgeons, librarians, etc.

If this multi-authored book is a true reflection of the rehabilitation field today, one may note interesting characteristics. There are many impassioned pleas for teamwork and repeated exhortations on the economic values of rehabilitation, with personal and social values mentioned secondarily. The writing often has a missionary quality; authors frequently write only about their own facility or program, mentioning few if any shortcomings. If it is true that "Rehabilitation seems to have come of age in the mid-twentieth century . . ." (p.856), then the time is ripe for a mature look at rehabilitation developments with all their strengths and shortcomings.—SALVATORE G. DiMICHAEL, U. S. Office of Vocational Rehabilitation.

## METHODS OF GROUP PSYCHOTHERAPY

By Raymond J. Corsini, Ph.D.

New York, McGraw-Hill Book Co., 1957. 251 pp.

Coming at a time when group psychotherapy is enjoying increasing and wide-

spread popularity, this book is of extraordinary value in presenting the history, therapeutic philosophies, scientific rationales, modes of application and methods of evaluation that have highlighted the rapid developmental course of this significant form of treatment.

As a scholarly and comprehensive summing up of the many important contributions that have been made to this remarkably complex field of interest, Dr. Corsini's pithy yet concise presentation is without an equal in the literature. The author's rich and varied background shows through in his able integration of abstracted material from over 400 reference items as well as in his sensitive selection of clinical examples.

The obviously great amount of effort invested in bringing together factual information from many sources, including some not readily available, will save every group therapy dilettante, neophyte, therapist, instructor, supervisor, consultant and dean much time in becoming acquainted with the truly vast scope of this promising system of care and field of study.

The chapters on history, comparison of theories, psychological mechanisms and methods and application of group psychotherapy make the book particularly valuable as a primer.

The author has clearly attempted to present an impartial and fair panorama of group psychotherapies. However, some bias is evident in subtle value judgments and omissions that punctuate the contents. This is especially evident in the book's treatment of psychoanalytic theory and therapy, which have contributed too much to the understanding and dealing with man's nature to merit the cursory discussions found in the book, as well as the equal-space implication that analytic

theory is comparable to any piecemeal hypothesis or postulate.

On this latter score discriminating readers will be disappointed by some of the passages which show lack of profundity and deserve greater elucidation. Examples of shallow references to sensitive areas of therapy and theory are the following: "... in any truly interactive group, the members progress roughly at the same rate." "There seems to be no question that what we call neurosis is essentially a breakdown of communication." "It is of interest that many modern students of psychoanalysis have abandoned the concept of the importance of instincts."

Were the author better versed in all the schools of thought he strives to outline, he would know the answer to his own question, "There is, however, one puzzling aspect about intellectualization. The patient often appears to have learned what he knew all along. Such statements as 'I always knew it, but I never really understood. . . .' or 'I have been told this many times, but somehow I never could believe . . . .' illustrate the paradox of learning in psychotherapy."

The author's entire concept of psychotherapy becomes particularly vulnerable when evaluated in the light of the following passage: "Furthermore, it is clear that the religious and therapeutic *means* (italics are reviewer's) whereby the good life is to be attained are essentially the same." This statement constitutes a serious confusion of goals and processes.

One of the disadvantages of attempted impartiality by an authority in a given field is the tendency to dilute anchorage concepts in a mass of controversy. This becomes evident when the author strives to answer the question: "Is group psycho-



therapy individual therapy, or is it something else?" In the many references to this question the important fact becomes obscured that group psychotherapy is a situation in which the *individual* obtains therapeutic benefits in a group setting.

Despite the misinterpretations and er-

rors, some of which have been mentioned, this is an important book. It is an outline and guide to serve as a good beginning for those who will augment their knowledge and proficiency through further reading and training.—MAURICE E. LINDEN, M.D., Philadelphia Department of Public Health.

# Notes and Comments

By mid-February, 40 national organizations with a total membership of close to 50,000,000 had expressed their enthusiasm for Operation Friendship and their intention of participating actively in this NAMH project. Its aim is to bring 750,000 visitors—as many visitors as patients—to the nation's mental hospitals during Mental Health Week, April 26 to May 2.

During this nation-wide, week-long "open house" three-quarters of a million citizens will get a first-hand view of mental illness and the mentally ill. NAMH believes the experience will go far to reduce the stigma which has for so long handicapped mental patients in their struggle back to health.

The national kick-off program will be held April 26 in Washington, D. C., where patients and high government officials will take part in an impressive ceremony at St. Elizabeths Hospital. As they ring the Mental Health Bell, cast from chains and shackles that once bound mental patients, they will touch off similar ceremonies in hundreds of other hospitals across the nation. Working with the NAMH public relations department, Chaplain Ernest E. Bruder of St. Elizabeths is coordinating details of the national kick-off program.

Wholeheartedly endorsing Operation Friendship, Dr. Winfred Overholser, the eminent superintendent of St. Elizabeths, wrote NAMH: "We look forward to joint participation in what we trust will prove to be a major venture in dealing with mental illness and its attendant concerns."

Another important endorsement comes from Dr. J. F. Casey, chief of neurology and psychiatry for the Veterans Administration. Of Operation Friendship he writes: "I think the idea of Operation Friendship is a very excellent one. We in the Veterans Administration have always cooperated to

the fullest extent in Mental Health Week and will do so this year. We will send out information to our various hospitals urging them to participate fully."

Operation Friendship is also expected to bring about closer ties between mental hospitals and the communities they are in or near. After seeing for themselves, visitors to the hospitals will have a much better understanding of the patients as sick people needing treatment, the project's backers believe.

The entire operation will carry out the Mental Health Week slogan: "With Your Help, the Mentally Ill Can Come Back."

The large national organizations which have already agreed to participate are the American Home Economics Association, American Nurses' Association, American Psychiatric Association, American Psychological Association, American Social Hygiene Association, Association for Family Living, Association of the Junior Leagues of America, B'nai B'rith, Boy Scouts of America, Camp Fire Girls, Central Conference of American Rabbis, Church of the Brethren, Civitan International, Council of Liberal Churches, Dale Carnegie Alumni Association and Fraternal Order of Eagles.

Others are the 4-H Clubs, General Federation of Women's Clubs, Ladies' Auxiliary of the International Association of Machinists, Lions International, Loyal Order of Moose, National Association of Social Workers, National Council of Catholic Men, National Council of Catholic Women, National Council of the YMCA's of the USA, National Council on Alcoholism, National Education Association, National Federation of Business and Professional Women's Clubs, National Grange, National Jewish Welfare Board, National League for Nursing, National Probation and Parole

Association, National Recreation Association, Optimist International, Salvation Army, Seafarers International Union, National United Community Fund, and Community of America, Veterans Administration and Zonta International.

These organizations are urging their state and local chapters to participate actively in Operation Friendship and to cooperate with mental health associations in publicizing the project and in arranging for their members to visit the hospitals. They are pointing out, "Your visit will enable you to observe what goes on in a mental hospital, to meet the hospital staff, to learn about the new and hopeful developments in the treatment of mental illness, to participate in interesting programs."

Besides eliciting formal endorsements from major mental health authorities and enthusiastic responses from major membership organizations, the "visit your mental hospital" idea has enormous appeal for the civic-minded of all ages. Take the Girl Scouts, for example.

Jumping the gun on Operation Friendship, the girls of Troop 206 in Osawatomie, Kans., have already visited the state hospital located there. Wearing their trim green and white uniforms, 23 girls and their leaders entertained patients on several wards. They recited the Scout's oath, sang some songs and visited with the patients, who pelted them with questions about their uniform and badges.

The girls explained that one of the requirements in attaining First Class Scout rating is to "plan a new adventure in friendship that you and your troop can carry out as a way of showing your thoughtful understanding of people in the community."

Setting an example for a whole nation to follow, the girls of Troop 206 voted to make their new friends among the mental patients of Osawatomie State Hospital.

## TRAINING

Four regional training institutes on mental health education in business and industry will be conducted by NAMH this spring and fall. They are to be held—probably in Hartford, Milwaukee, New Orleans and San Diego—for the staff members and professionally trained volunteers who are responsible for expanding the educational services provided by state and local mental health associations.

Each 3- or 4-day course will be led by Dr. Harry Levinson, director of industrial mental health for the Menninger Foundation. Each will focus on the content and techniques that have proved most useful in the organization of mental health programs in business offices and factories.

Among the topics that will be covered are the psychodynamics of behavior, personality problems in communication, personality factors in leadership, and problems of executives.

At the first session, participants will discuss the various educational services that mental health associations should provide for industrial workers. As a special feature of the 2nd and 3rd sessions, Dr. Levinson will demonstrate exactly how to conduct a 2-day workshop for a small group of local industrial executives. In each community he will have the help of local psychiatrists and psychologists. At the final session, the mental health association representatives will analyze the techniques used by Dr. Levinson in the demonstration. They will also work out various problems typical of those that arise in the development of industrial mental health programs.

On returning home, participants will schedule similar 1- or 2-day workshops for local business and industrial leaders. As a further service, they will also arrange for small groups of executives to meet regularly to go over the mental health problems that



arise on the job. These unique clinical group education sessions, in which selected local business leaders regularly analyze human relations problems in their own organizations, are foreseen as the primary dividend from the four institutes.

As another aid to mental health associations, NAMH will publish a manual based on Dr. Levinson's lectures and demonstration. It will serve as a ready-reference guide in organizing and expanding this mental health service to the community.

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Grants to further the training of four Protestant ministers and three Roman Catholic priests who will pursue careers as chaplains in mental hospitals or train others in mental-health chaplaincy have been awarded by the Academy of Religion and Mental Health, New York.

The awards, totaling \$4,050, were made under the chaplaincy fellowship program of the Smith, Kline & French Foundation, Philadelphia. The academy made three similar grants last year under the same program.

• • •

The 17th annual session of the Yale University summer school of alcohol studies will be held from June 28 to July 23. There will be lectures, seminars and workshops for a maximum of 275 students. Further information is available from the Registrar, Yale Summer School of Alcohol Studies, 52 Hillhouse Ave., Yale Station, New Haven, Conn.

• • •

Sixteen more grants for in-service training of workers in mental institutions of southern states have been awarded by the Southern Regional Education Board.

The grants went to staff members of mental institutions in Kentucky, Louisiana, North Carolina, South Carolina, Virginia and West Virginia. A total of 47 grants have now been made by SREB under this program.

The SREB grants, made possible by a \$90,000 subsidy from the National Institute of Mental Health, are designed to enable staff members of southern mental hospitals or training schools to observe new or unusual programs in hospitals anywhere in the country to help them improve their own programs.

Grants are available to administrative, professional and operational personnel such as ward attendants, aides, nurses, rehabilitation personnel, clinical directors, superintendents and others.

Applications for the grants are still being accepted by SREB. There is no deadline, and applications are acted upon as they are received. Applicants should write directly to the Southern Regional Education Board, 881 Peachtree St., NE, Atlanta 9, Ga.

## CARE AND TREATMENT

In his inaugural address to the Connecticut legislature Gov. Abraham Ribicoff called for:

- The establishment of a mental health center in New Haven in connection with the Yale University Medical School.
- The establishment of community hospitals as branches of the state's mental hospital program.
- Replacement of an antiquated building at the Connecticut State Hospital with a community psychiatric hospital of 250-300 beds.
- The creation of facilities for more chil-

drawn at the Connecticut Child Study and Treatment Home.

- The expansion of community psychiatric clinics.

. . .

Last year, as one of the final phases in a detailed appraisal of New Jersey's mental hospital program, seven of the state's hospital superintendents studied the administration of Britain's famed open hospitals. Returning from their tour they formulated a set of principles based both on their self examination and on their observations in Britain.

Their statement of principles—designed to lift the therapeutic level of all New Jersey's mental hospitals—was presented to each institution's managers and to the Board of Control of the State Department of Institutions and Agencies. At its February 19 meeting the board approved the principles as reflecting the official policy of the state government.

The full statement follows:

WHEREAS it is generally accepted that psychiatric disabilities are illnesses in the medical sense of the term, and that the symptomatology shown by a majority of psychiatrically ill patients is not of an aggressive, anti-social or purposefully self-destructive nature; and

WHEREAS it is believed that patients suffering from such disorders respond best to treatment given with considerate understanding of the feelings and sentiments of those so afflicted, in an environment which does not of itself alarm the fearful or challenge the uncooperative; and

WHEREAS the reports of the Medical Directors have pointed to the medical effectiveness of programs in the United States and in Great Britain which give full recog-

nition to these principles. Therefore be it RESOLVED, that the State Board of Control affirms as its policy the encouragement in these institutions of programs for the improvement of the physical surroundings in which patients live, and the continued development of practices which insure for all patients the greatest amount of self-determination and personal liberty compatible with their clinical state.

In furtherance of this policy the Director of Mental Health and Hospitals will consult with the Medical Directors of the several hospitals concerned, with a view to the expeditious removal of clinically inappropriate restrictions and the development of physical surroundings more conducive to the patients' mental health.

It is anticipated that the Director of Mental Health and Hospitals and the several Medical Directors will:

1. Study the effects of a materially higher percentage of voluntary admissions on the patient, the hospital and the community.
2. Re-examine our regulations and attitudes toward the easy readmission of patients to hospital.
3. Scrutinize the pre-admission services offered decompensating individuals with a view to facilitating hospitalization when it is necessary and acquainting them with alternative community services when it is not.
4. Assess the nature and extent of the responsibilities given our nursing personnel in order to capitalize as fully as possible on their unrealized potential.
5. Examine our traditional insistence that eradication of pathology is the only proper medical goal and to determine whether an equally important end may not be the social rehabilitation of the patient.
6. Explore the possibility of day care

programs for those aged individuals who would otherwise require hospitalization.

7. Determine the extent to which living arrangements for our patients can be improved through assurance of an increased measure of privacy, interior decoration of buildings, reduction in the size of nursing units, rearrangement of beds, development of recreational space and playing fields, replacement of unsatisfactory furniture, and individualization of patients' dress.

8. Work for the reduction in the bed capacities of all our hospitals and to insist on the construction of new institutions if the alternative is the erection of bed containing buildings at existing installations.

9. Examine our whole system of clinical records with a view to retaining whatever is essential and eliminating all that serves no clear purpose.

10. Investigate alternative methods of budgeting which offer promise of simplifying the fiscal administration of our hospitals.

\* \* \*

Dr. Bertram Mandelbrote, a leading English spokesman for the open (unlocked) mental hospital, will arrive in this country early in April for his third series of conferences with U. S. mental hospital officials. This trip, like the two which preceded it, was organized by NAMH and affiliated state mental health associations.

Immediately on arrival Dr. Mandelbrote will take part in the mental health telethon to be held April 4-5 in New York City. His tentative itinerary then includes Jacksonville, Fort Lauderdale and Miami, Fla.; Columbia, S. C.; Austin and Galveston, Texas; Des Moines; Galesburg, Ill.; Minneapolis; Philadelphia and Reading, Pa.

In each of these cities he will pass on to the heads of mental hospitals and mental health associations the benefit of his expe-

rience as the administrator of two open hospitals in Gloucester. Good hospital-community relations and an informed, interested public are essential to the success in the opening of mental hospitals, Dr. Mandelbrote has found.

He has now carried the open hospital idea to almost a third of the U. S. On his first trip, late in 1957, he visited 11 public and private mental hospitals in New York and New Jersey. On the second, last year, he talked with hospital administrators in Connecticut, Massachusetts, Maryland, Indiana, Illinois, Michigan, Ohio, Missouri, Louisiana and Washington, D. C.

In Reading, Dr. Mandelbrote will also discuss fundamental changes in the laws of the United Kingdom regarding the mentally ill, now pending before Parliament. The changes proposed are designed to give the maximum encouragement to patients suffering from any form of mental illness or disability to seek treatment promptly and voluntarily but at the same time to insure that there are adequate restraints and safeguards for patients who, in their own interests or for the safety of others, must be compulsorily admitted to the hospital and detained during treatment.

The bill provides for:

- A single legal code to cover both mental illness and mental deficiency.
- Care for any type of mental patient in any type of hospital rather than in designated hospitals.
- The establishment of a mental health review tribunal for each of the 15 hospital regions in England and Wales, with power to discharge patients.

Other topics covered in the proposed law are categories of patients, special provisions for psychopathic and subnormal patients, detention safeguards, powers of discharge.



powers of the courts, and protection of the public.

If and when the bill becomes law, **MENTAL HYGIENE** will excerpt those elements of special interest to U. S. readers. Meanwhile, copies of the bill and a discussion of it are available on short-term loan from Dr. George S. Stevenson, editor. They can also be obtained from the British Information Services, 45 Rockefeller Plaza, New York 20, for \$1.25 postpaid for the bill and 23¢ postpaid for the parliamentary debate.

\* \* \*

Haiti recently dedicated a new psychiatric institute, built with funds supplied by three U. S. drug companies. It is headed by Dr. Louis Mers, for many years Haiti's only psychiatrist and the founder of the National Mental Hygiene League.

\* \* \*

Extensive psychiatric procedures are now covered by the New York State workmen's compensation fee schedule. A new schedule which went into effect March 1 calls for higher fees and increases payments for rehabilitation procedures.

Psychiatrists are now allowed \$25 for the initial interview, up to \$200 for shock therapy and up to \$225 for psychotherapy in the doctor's office or in a hospital. Under the old schedule they were paid only for the initial psychiatric interview, with the fee set at \$15.

Rehabilitation specialists will now be paid for such services as psychosocial determination, vocational guidance, daily activities testing and physical and occupational therapy. Under the old schedule they were allowed only \$25 for examination, observation and consultation.

\* \* \*

More mental health services are America's

top priority community need, a nationwide panel of federal, state and local public health directors said recently.

The officials were polled by the American Public Health Association in the first of a series of surveys aimed at keeping track of shifting public health trends.

\* \* \*

Conversion of employees' quarters at Pennsylvania's state mental hospitals to the use of patients has added 2,055 beds.

It would have cost the state \$12,330,000 to provide similar new facilities, according to Public Welfare Secretary Harry Shapiro. Remodeling cost \$182,640.

Eighteen of the 21 institutions have remodeled buildings formerly occupied by employees to provide 14 rehabilitation centers, 31 therapy areas and 87 offices, conference rooms, lounges and nursing stations.

\* \* \*

On every hand these days is telling evidence that mental patients are breaking through the barriers that long isolated them from the rest of the community.

For example, five years ago not one general hospital in Kansas would take mental patients. Now 68 of the state's 167 licensed hospitals will accept them, for temporary care at least.

\* \* \*

The third intensive treatment unit for newly admitted geriatric patients opened last year at Hudson River State Hospital, Poughkeepsie. It was organized by the New York State Department of Mental Hygiene.

The unit is treating patients over 65 with psychiatric conditions who stand to benefit from intensive therapy. Its aim is to rehabilitate as many as possible so that they can return to their families or be

cared for in foster homes supervised by the hospital's social service department.

The intensive treatment program includes medical and nursing care, physiotherapy, occupational therapy, psychotherapy and tranquilizing drugs. Social work counseling is also provided.

Similar units were set up in 1956 at Central Islip and Buffalo State Hospitals.

• • •

Volunteers are providing each new patient at Willmar (Minn.) State Hospital with a "welcome packet"—an expansion envelope containing a pencil, stationery, postage stamps, a calendar and an address book. The envelope, a handy place for the patient to store letters from his family and friends, bears his name and the following message: "This correspondence folder is a gift from the volunteers of the community, who wish you a short stay at the hospital."

• • •

Adequate care of Pennsylvania's mental patients and retarded children will cost at least \$185,000,000 or \$190,000,000 during the next two years, according to figures compiled by Pennsylvania Mental Health, Inc., NAMH affiliate.

The 17 state hospitals with their 39,000 patients will need most of this—\$150,000,000. Increased facilities for mentally retarded children—there are 2,500 on the waiting lists of the four overcrowded state schools—and improvements will take another \$32,500,000.

The Eastern Pennsylvania Psychiatric Institute, the state's major research and training installations, will need \$6,000,000 during the next two years, study shows. Another \$8,000,000 ought to go into state aid for 32 community clinics, psychiatric beds in general hospitals, mental health

centers, and foster home, boarding home and special after-care programs.

PMH figures a minimum of \$3,000,000 will be required for residential care and treatment of the state's mentally ill children. Well-distributed diagnostic centers are needed, as well as small expertly-manned treatment centers.

Sound leadership of the state program will cost \$3,000,000, Pennsylvania Mental Health estimates. This allows for competent administrative aides to the State Commission of Mental Health, for specialists in the various mental health disciplines, and for the training of additional psychiatrists, psychologists, psychiatric social workers and nurses.

By July 1, 1961 Pennsylvania will be spending at the biennial rate of \$202,500,000 if it is to provide adequate care for the mentally ill and retarded, the NAMH affiliate foresees.

• • •

A 5-year program to improve mental health facilities in Louisiana is getting underway under the joint auspices of the Louisiana Association for Mental Health and the State Department of Hospitals.

Dr. Loyd Rowland, executive director of the association, said the first objective was to obtain an adequate appropriation for the state's mental hospitals.

"Louisiana has been next to the lowest among the states in spending money for mental hospitals," he said. "If we are going to reduce the size of our mental hospitals, we must first spend money to get better services for them. We shall get what we pay for, and no more."

Other recommendations call for more open wards, larger staffs and smaller hospitals, family care programs, use of nursing homes and volunteer help programs, case

reviews for hospitalized patients, mental health treatment centers for outpatients, larger staffs for guidance clinics, psychiatric wards in all public hospitals, and increased mental health education.

Jesse Bankston, director of the hospital department, said:

"This program represents goals which we feel are within our reach. Our objectives are reasonable, and with hard work and cooperation of the public and our state and local officials, we can expect to achieve them."

### REHABILITATION

Five patients were discharged recently after spending a total of 183 years in Kentucky's Western State Hospital.

Four went to a nursing home and the fifth to a job obtained with the help of the hospital. The oldest, a man of 81, had been at the hospital 51 years. Three others were 77, in the hospital 54 years; 74, hospitalized 48 years; and 80, admitted at 60.

Last year almost 50 patients 65 or over have left this hospital for nursing homes.

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Fifty-one patients of Greystone Park (N. J.) State Hospital are studying public speaking. The 10-week course is conducted by the Morristown Speakers Club and professional men from Dale Carnegie, Inc.

### LEGISLATION

Dr. Paul V. Lemkau of Baltimore is the first chairman of the new legislative committee of the National Association for Mental Health. Dr. Lemkau, a psychiatrist, is professor of public health administration at Johns Hopkins University and a former director of New York City's Community Mental Health Board.

Other members of the committee are

James S. Adams and Dr. William Malamud, New York City; David C. Crockett, Boston; and Paul Johnston, Birmingham. Mrs. Virginia Beecher Smith is serving as the staff coordinator.

The committee's purpose is to provide information and guidance on federal and state legislative matters to mental health associations, and through citizen action to achieve the basic NAMH objective of working toward "the improved care and treatment of the mentally ill and handicapped; for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illnesses and handicaps; and for the promotion of mental health."

The committee's primary function is to recommend to the NAMH board the establishment of policies affecting the legislative program. In doing this, the committee will:

- Obtain, evaluate, recommend and disseminate information on federal legislation, including budgets, related to the mental health field.
- Recommend an official position on national mental health legislation and budgetary matters.
- Implement this position by appearing before legislative bodies and other groups, and in other ways.
- Disseminate information to state and local mental health associations concerning this official position, to the end that coordinated support be obtained.
- Furnish state mental health associations with available information on existing state legislation.

The committee has announced that policy decisions on state and local legis-



lative matters will remain the exclusive prerogative of state and local mental health associations. The committee will serve in a consultative capacity and only when invited to do so.

For the present, at least, the committee expects to concern itself primarily with legislative matters of the National Institute of Mental Health of the U. S. Department of Health, Education and Welfare. It is likely also, Dr. Lemkau said, that the committee will propose the adoption by all states of the Interstate Compact, a reciprocal agreement now in force among 11 of the 49 states which provides for hospitalization of non-resident mental patients.

As a long-term project, the committee expects to draft a legislative guide for state and local mental health associations.

The committee has accepted, in principle, a resolution calling on Congress to increase the amount of federal funds available to the states as grants-in-aid for community mental health services. For a number of years the appropriation for this purpose has been set at \$4,000,000. The resolution was submitted by the Alabama Association for Mental Health.

## RESEARCH

A 10-year study of the adjustment made by discharged mental patients is getting under way at Moose Lake State Hospital near Duluth and in St. Louis County, Minn. It is being conducted by the National Institute of Mental Health in cooperation with the Minnesota Department of Public Welfare.

The long-range investigation is expected to provide guidelines for effective use of follow-up services and community resources in the rehabilitation of discharged patients throughout the nation. Relationships among the hospital, the patients and the community will be studied, according to

Dr. Joseph C. Lagey, director of the project. A major objective will be to determine what kinds of services are most useful to the 12,000 patients expected to be discharged from Moose Lake State Hospital during the next 10 years.

A staff composed of 15 psychologists, sociologists, social workers and clerks is working on the project in close cooperation with Dr. Henry Hutchinson, superintendent of the hospital, and his staff.

\* \* \*

The mental health of patients and personnel in general hospitals is to be the subject of an international study under the auspices of the International Council of Nurses, International Hospital Federation and World Federation for Mental Health. Member associations of these world bodies in 12 countries including the U. S., have been asked to participate.

It is hoped that the study report will be a significant feature of World Mental Health Year. The investigation is being financed by the Grant Foundation, New York City.

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The first applications for grants under the expanding research program of the National Association for Mental Health will be acted on this month by a committee of 12 nationally-known medical scientists and health authorities.

The program is headed by Dr. William Malamud, NAMH research director and former chairman of the division of psychiatry at Boston University. Members of the committee include:

Dr. Harold W. Elley, retired director of research for E. I. duPont de Nemours & Co., chairman.

Dr. Philip Bard, dean of the medical faculty at Johns Hopkins University and

director of the department of physiology.

Dr. Francis J. Braceland, psychiatrist-in-chief of the Institute of Living, Hartford, Conn.

Reginald G. Coombe, 1st vice-chairman of the NAMH board.

Dr. John C. Eberhart, executive associate of the Commonwealth Fund.

Dr. George E. Gardner, psychiatrist-in-chief, Children's Hospital, Boston; professor of psychiatry, Boston University Medical School; member of the mental health study section of the National Institutes of Health.

Dr. Ernest M. Gruenberg, member of the technical staff, Milbank Memorial Fund; clinical professor, Columbia University; former executive director of the New York State Mental Health Commission.

Dr. Seymour S. Kety, associate director in charge of research, National Institute of Mental Health; professor of clinical physiology, University of Pennsylvania School of Medicine; former medical director of the U. S. Public Health Service.

Dr. Morton Kramer, chief of the biometric branch of the National Institute of Mental Health; former statistician for the New York State Department of Health.

Hugh G. Payne, executive officer, Oklahoma Medical Research Foundation.

Dr. Heinrich Waelsch, chief biochemist, New York State Psychiatric Institute.

Dr. Stewart Wolf, chairman, department of medicine, University of Oklahoma Medical School.

A \$100,000 contribution to the program by the Rockefeller Brothers Fund was announced last December. The gift, to be applied over the next four years, is in addition to the fund's annual contributions to the association.

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French researchers, studying weight increments of infants from 3 to 18 months of

age in a residential nursery, found that more than 100 of the infants gained weight regularly in the last weeks of each calendar month but did not gain during the first 10 days of each month. This periodic arrest of weight gains was attributed to the complete turnover of student baby-nursing personnel on the first day of each month. In a comparable nursery where personnel were not rotated, most infants gained regularly in the first half of the month.

The study is reported by Paul Bertoye and C. duMorand of the Pouponniere de la Croix-Rouge in Lyon in an article, "Troubles de croissance du nourrisson par choc affectif," (Disturbance of the Growth of Infants Caused by Emotional Upset), *Revue d'Hygiene et de Medicine Sociale* (Paris), 5(1957), 187-89, and abstracted by W. M. Schmidt in *Child Development Abstracts and Bibliography*, 32 (3 and 4, 1958), 81.

## PUBLIC INFORMATION

Radio station KGDE in Fergus Falls, Minn., is promoting closer hospital-community relations by regularly including in its round-up of local news a report of events at the state hospital located there. The stories, which cover daily activities, give the public a good idea of what goes on at the hospital and what is done for the patients.

\* \* \*

The Advertising Council has voted to continue its nation-wide Better Mental Health campaign for another two years at least.

Working as a team with the National Association for Mental Health, the council has already distributed thousands of advertisements for use by television and radio stations, outdoor advertisers, newspapers, magazines and transit companies. Each ad

stresses the need for better understanding of the 17,000,000 Americans who are to some degree afflicted with mental illness.

Sullivan, Stauffer, Colwell and Bayles, a New York advertising agency, volunteered to create ads for the campaign.

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Mental illness and mental health in the world today will be the theme of World Health Day, to be observed April 7.

## MEETINGS

Shifts in treatment of the mentally ill have created a great demand for more social workers, the Council on Social Work Education was reminded at a meeting in January. Greater appreciation by social workers of the role played by mental health volunteers is also essential, it was said.

Mrs. Ruth I. Knee, psychiatric social work consultant for the National Institute of Mental Health, said the removal of bars and locked doors from mental hospitals symbolizes the changing attitude in patient care. The community and family are closer to the patient, he participates more fully in democratic life in the hospital and his separation from the community is not so long, she pointed out.

The growth of psychiatric units in general hospitals—there are now 1,000 compared to less than 50 ten years ago—was also said to help fill the gap between the patient and his family.

These changes require more work with the patient in his home and community, family counseling and assistance, Mrs. Knee said.

Miss Mary Mackin, NAMH director of volunteers, called on social work educators to develop a greater understanding of the unique contributions of mental health vol-

unteers. She pointed out that social work schools should broaden their curricula to include courses on staff-volunteer relationships and on the training, supervision and recognition of volunteers.

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The 3rd Latin American Congress on Mental Health was held October 27 to November 15, 1958 in Lima, Peru, under the auspices of the Peruvian government. All Latin American countries participated, plus Haiti, Puerto Rico and French Canada.

The main topic—the present state of Latin America's mental health—was considered from 6 angles: mental illness in urban and rural areas; migration and intercultural conflicts; alcoholism and dope addiction; industrial mental health; community organization for mental health, and social problems such as delinquency and prostitution.

There was special stress on community organization, with discussions centering on the influence of the community and of housing on mental health; cultural and educational influences on youth; family organization and mental health; and surveys and the evaluation of plans for mental health services.

The Latin American countries were advised to intensify their studies of the extent of mental illness in both rural and urban areas as the basis for effective, coordinated community mental health planning. They were also urged to establish psychiatric services in general hospitals, to create mobile services to handle psychiatric problems in rural areas, and to provide more psychiatric training for general practitioners.

Participants took note of the value of transcultural studies in Mexico, Peru and Cuba. They also considered the possibility



of integrating into the immigration services of each country psychiatrists and other technicians equipped to foresee and handle problems arising out of migration.

Campaigns against the use of alcohol and toxic drugs should be intensified, the participants decided, agreeing to sponsor a seminar this year in Santiago on alcoholism in Latin America. It was also suggested that the best way of combatting drug addiction in the Latin American countries is to raise the standard of living among those who use drugs as a substitute for food. The public health ministers of the affected countries were urged to confer on this problem.

Pointing to the rapid increase of industrialization in the area, the congress recommended the establishment of human relations institutes and centers for the study of industrial psychology.

Other speakers noted the need for coordinating housing and mental health planning; for improving children's literature and movies, as significant influences on mental health; for studying the economic and social causes of delinquency; for modernizing the child welfare laws; and for providing penal and correctional institutions with the services of psychiatric teams.

The Latin American Association for Mental Health, meeting in Lima in conjunction with the congress, elected the following officers: Dr. Carlos Nassar, Chile, president; Dr. A. C. Pacheco e Silva, Brazil, vice-president; Dr. Baltazar Caravedo, Peru, general secretary; Dr. Alberto Mateo Alonso, Venezuela, treasurer; Drs. Mario Sbardì of Argentina, Jose A. Bustamante of Cuba, Ricardo Ponce of Guatemala and Jose M. Alvarado of Bolivia, directors; Drs. Guillermo Correal Sanin of Colombia and Ricardo Rodriguez Pane of Paraguay, substitute directors.

Both the congress and the Latin American association plan to participate in the observance of World Mental Health Year.

The 4th congress will be held in Santiago in 1960, the 5th in Caracas in 1962.

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Mental health workers from scores of countries will gather in Barcelona August 30 to September 5 for the 12th annual meeting of the World Federation for Mental Health. The Liga Española de Higiene Mental will be host. "Planning for Mental Health" will be the theme of all sessions.

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The 7th annual Karen Horney Lecture, sponsored by the Association for the Advancement of Psychoanalysis, was given March 25 in New York City by Dr. Leo Kanner. His topic was "Centripetal Forces in Personality Development." Dr. Bella S. Van Bark is chairman of the lecture committee.

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The 41st annual meeting of the Canadian Mental Health Association will be held June 2-4 at the Chateau Laurier in Ottawa. Dr. J. D. Griffin is general director.

\* \* \*

Cincinnati will be the site of the annual convention of the National Association for Retarded Children. The dates are October 21-24. Registration is open and the organization invites members of all professions interested in the welfare of the mentally retarded. Further information is available from Dr. Gunnar Dybwad, executive director, 99 University Place, New York 3.

\* \* \*

Scientists from 20 major U. S. research

centers will participate next month in a 5-session conference on research in mental retardation. It will be held May 1-3 in Philadelphia under the auspices of the Woods Schools, Langhorne, Pa., and the American Association on Mental Deficiency.

The meeting is expected to attract professional workers, research scientists, parents and educators. Cooperating will be the National Institute of Mental Health, Office of Vocational Rehabilitation, Children's Bureau, Office of Education, National Institute of Neurological Diseases and Blindness, American Psychiatric Association and Children's Hospital of Philadelphia.

Papers read during the conference will be published in the *American Journal of Mental Deficiency* and also by the Woods Schools.

\* \* \*

The first international medical conference on mental retardation will be held July 27-31 at the Eastland Hotel in Portland, Me. It is being organized by the Maine chapter of the American Academy of Pediatrics, the division of maternal and child health of the Maine Department of Health and Welfare, and the Pineland Hospital and Training School at Pownal.

The program will include addresses on brain anatomy, head anomalies, phenylketonuria, birth injuries, infections, mongolism, behavior disorders and psychotherapy.

#### APPOINTMENT

Dr. William P. Hurder has been selected to head the South's regional program in mental health training and research conducted by the Southern Regional Education Board. Announcement of his appointment as SREB's associate director for mental health was made February 16 by Dr. Robert C. Anderson, director of the board.

Dr. Hurder holds the M.D. degree as well

as a Ph.D. in psychology, thus combining in his professional training two key areas in the field of mental health. Before joining SREB in 1957, he headed the State Colony and Training School in Pineville, La. From 1949 to 1954 he was assistant and associate professor of psychology and psychiatry, and psychiatric research associate at Louisiana State University.

The regional mental health program was established in 1954 by the SREB at the request of the Southern Governors' Conference and is supported by an appropriation of \$8,000 from each participating state. Its purpose is to aid states and southern colleges and universities to train more qualified personnel for mental health programs and to aid in obtaining added support for needed research programs.

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Ephraim Roos Gomberg, a Pennsylvania attorney, has been appointed director of the 1960 White House Conference on Children and Youth. He will carry out the directives of the President's national committee for the conference, of which Mrs. Rollin Brown is chairman.

#### MEMORIAL

A committee of friends and colleagues of the late Dr. Lawson G. Lowrey has been formed and is appealing for funds for a suitable memorial. Contributions made payable to the Lawson G. Lowrey Memorial Fund may be mailed to Simon H. Tulchin, 30 E. 60th St., New York 22.

#### PUBLICATIONS

A revised edition of a manual titled *Volunteer Participation in Psychiatric Hospital Service* was released recently by the National Association for Mental Health.

The original manual, published in 1950, was widely used by hospital staffs and by various community groups. The revision

is written specifically for the hospital chairmen of local mental health associations. It will be particularly helpful to those near enough to state hospitals to give personal service to patients, and to associations serving the psychiatric wards of general hospitals and county homes.

The manual supplies detailed information on the necessary steps in setting up a program of services to the hospitalized mentally ill. It points out that the services—to be fully effective—must rest on a solid foundation of planned partnership between the mental health association, the hospital and the community of which they are part. It clearly differentiates between the roles of the mental health association (working through its hospital committee) and the hospital (working through its director of volunteers). It also notes the value of a community coordinating council for mental hospitals and shows how the mental health association can work with other groups in setting up a council.

Several sections of the manual are devoted to the many kinds of services that volunteers can give to the hospitalized mentally ill. There are guide lines and suggestions on recruiting, matching the volunteer to the job, training volunteers in the community and in the hospital, and introducing them to assignments and supervision. Suggested forms, examples of job descriptions, and a list of do's and don'ts are included.

A companion piece directed to mental health associations located at some distance from a mental hospital will soon be published. It will discuss the kind of services associations can provide for patients in a remote hospital.

\* \* \*

The most promising of modern weapons in the battle against mental illness are described in a new NAMH publication, *New*

*Trends in the Care and Treatment of the Mentally Ill*. It was written by Leonard Engel, a topflight free-lance journalist, for wide distribution by mental health associations.

"Much that is heartening in the fight against mental illness is attributable to state and local mental health associations across the country and to the dedicated efforts of their members," says the foreword. "These people have just reason to be proud and the purpose of this pamphlet is to tell them something about the achievements that their dedication has helped to inspire and make possible."

The new pamphlet supplies a great deal of information for speeches, round-table discussions, study programs and forums. It will also be useful to libraries and to students, particularly in health, social science and psychology courses. Many other uses for the pamphlet are listed in a guide prepared by the NAMH education department.

Copies of *New Trends* are available from NAMH for 15¢ each, with special prices for quantity lots.

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His own battle against mental illness is recounted by Robert E. Dahl, central regional director of the Indiana Association for Mental Health, in *Breakdown*, to be published March 30 by the Bobbs-Merrill Company.

He wrote the book, he says, because today he can see signs of hope for the mentally ill.

"There are new drugs which help calm patients and make it easier for the doctors to talk with them. In many places wards are being opened. A few state hospitals are unbarring all their windows, unlocking all their doors. Yet, despite such progress, Tag, Albert, Baker and Hiram still are confined in River's Edge. They and many



others that I knew probably will die there. This is my way of remembering them.

"And this book also is my way of remembering that far greater number—those who have been discharged by the hospital. I also write to those still to enter it. I write to all those who have shared, or who will share, experiences akin to mine—that they may know the fight is truly worth while."

Mr. Dahl, who lives in Lawrence, Ind., with his wife and two young daughters, is a graduate of the University of Missouri School of Journalism. Before joining the staff of the Indiana mental health association, he worked in the advertising department of the Indianapolis Times.

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Spanish-language editions of three popular mental health leaflets have been produced

by NAMH for distribution through church organizations, social and fraternal groups and health departments. The leaflets are *What Every Child Needs for Good Mental Health*, *Some Things You Should Know about Mental and Emotional Illness* and *Mental Health Is 1-2-3*.

Mental health associations in Spanish-speaking areas have long reported a need for the leaflets, which easily and quickly familiarize readers with basic mental health ideas.

The translations, prepared for NAMH by the Puerto Rican Department of Health's mental hygiene bureau, have been approved by Spanish-speaking Americans of Mexican and Cuban backgrounds.

Quantities of each are available from NAMH at the following prices: 100-999, \$1.90 per 100; 1,000-9,999, \$1.80 per 100, with still lower prices for larger quantities.

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## *Notes and Comments*



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BERTRAM SCHAFFNER, M.D.

# Thoughts about therapy today

I have wondered what might be the real reason for the current tremendous preoccupation with Zen Buddhism and other oriental philosophies of life. Is this a manifestation of our interest in therapy, or could it indicate some feeling of dissatisfaction with contemporary therapy? What is the real reason that so many psychoanalysts are browsing in the literary and philosophic pastures of existentialism? Or in the fields of ethics and systems of values? Why are some analysts placing so much emphasis on sociological structures, real or ideal? What lies behind the recourse to the mystical? Or the constant reference to the "I-Thou" relationship as the cornerstone of therapy?

I believe that a good number of today's analysts who are delving into other fields do so to expand their horizons and to acquire new therapeutic insights. But I also believe that there are many analysts today deeply affected by what I would call, until I can

describe it better, a kind of therapeutic pessimism. It is the reverse of the therapeutic optimism with which I believe most of us entered into this terribly difficult profession. I don't mean to imply for one minute the simple optimism that one can successfully treat all kinds of mental illness or every patient that might come for treatment. I have in mind the spirit which gave full recognition to people's need for psychological help but also believed that a therapist could attain some degree of sureness about how he was working and what he was working toward. I suppose that by therapeutic pessimism, I really mean a group of feelings possessed by an analyst, feelings of uncertainty about psychological theory, un-

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Dr. Schaffner, who is a psychoanalyst in private practice in New York City, presented this paper May 19, 1958 as a presidential address before the William Alanson White Society.

certainty about psychological illness, about human nature, about human health, uncertainty about therapeutic goals, even uncertainty about what one has the right to regard as therapeutic success. I believe that many an analyst has felt a lack of foundation, direction or clarity in his own attitudes towards his patients and his work, and that for many it has meant the difference between satisfaction or dissatisfaction with one's chosen career. I believe that many have experienced a kind of major disappointment, which it has been difficult to share with others, especially since they were not sure whether any clarification was to be had. It is my observation that gnawing feelings of therapeutic unclarity and inadequacy and helplessness have been quite prevalent, though usually unspoken, and that these feelings may even have been connected with certain tensions and dissensions that superficially seemed quite unrelated.

I do not feel that the pessimistic analysts have lost their basic hope or faith in psychoanalysis as such, but rather that they have at times become deeply discouraged. They have profoundly missed a sense of definition, of precision, of process such as they feel is available in other sciences—all the more troubling, perhaps, because of their strong sense of responsibility toward the lives of their patients. In our field of psychoanalysis it is not easy to know where to turn for one's answers. There are many books and there are many answers. The profusion itself is disconcerting. Often the system-builders merely preach their own private doctrines. Usually his supervisors turn out to be the psychoanalyst's best resource. Many of them have found satisfactory working answers for themselves. Some supervisors are excellent at communicating these answers; some do not quite have the words or the formulations with which to communicate them to others.

Even Frieda Fromm-Reichmann, who was certainly a therapeutic optimist in the sense that I used the phrase earlier, had considerable worry about teaching others what she knew. Her brilliant and ingenious responses to patients were not haphazard or quixotic; they had a consistent basis in her way of viewing life and disease, and in her concepts of stimulating healthier reactions. Still she felt she had not yet found the way, the proper words, the appropriate psychological units, with which to explain to others her own therapeutic manoeuvres. In the fall of 1955 she told me that she felt the only ultimate hope lay in helping each young therapist to free and develop his own intuition. The next year, when she was in Palo Alto, she began to feel a bit more hopeful about methods of communicating to others what she herself knew and what she was doing in the therapeutic process.

Perhaps the simplest way of trying to express the undercurrent of insecurity about therapy would be to say that somehow it does not seem to be "true to life," that in some ways it fits and then in other ways it does not, that the *theory* seems to satisfy, but in application it somehow falls short, that it somehow lacks psychological realism. I have often had the impression that the current search into philosophy, Zen Buddhism and existentialism, represents partly a flight from discouragement, but may also represent one kind of positive attempt to find a way to view patients more in keeping with life as we feel it in ourselves. Some good undoubtedly has come from the search. The comparison of our points of view with any other, especially one as different as Zen, also has a particularly encouraging effect, since it emphasizes that one is to go on trying and trying, no matter how intricate and difficult the task, partly because of the joy of experiencing one's un-

known capabilities, but also because one will ultimately find the solution within oneself. Zen stresses learning without excessive dependency upon one's teacher, and by implication enables one to ignore frustration in self-disciplined pursuit of solutions to life's puzzles. The particular puzzles presented, however, have often puzzled me; they seemed to be an evasion rather than a meeting and facing of life.

In Martin Buber's philosophy, if I understand it correctly, the image again is not quite lifelike. There is a heart-warming appeal to human beings to speak out to one another, to trust one another. Certainly Buber stresses the importance of direct confrontation and communication on the emotional level. It seems to me that he speaks movingly for all those who have lived in some form of isolation and despair, whether it be isolation caused by hostility from outsiders or isolation caused by fear from within. He knows well the despair stemming from the seeming inability ever to break through the barriers of hostility. He speaks with the conviction of a man who no longer has to live alone, because he has found through an act of will or faith the means to live with other human beings. It is a crusade for trusting vibrant contact, without which a man cannot have a full life. It might be perilous, however, to feel that the direct emotional I-Thou contact can really restore a sick human being or in itself solve life problems. In fact, in today's world some problems might even be characterized as caused by an overabundance of I-Thou contact. The various mystics, I feel, describe experiences which doubtless had their origin in real life events, but it has always seemed to me that the real meaning or helpfulness of their experiences were lost because of the inability of the mystics to analyze and describe clearly what had taken

place. Too often we are lured by the exoticism of an experience which we cannot examine critically because we have not been given the means to understand it at all.

Perhaps the search into existentialism uncovers something a bit closer to life as we feel ourselves to be living it, closer certainly than the life pictured by the early Freud. For example, mothers are differentiated individuals and not all similar because they are all mothers; the absolute starts to give way to the relative. In existentialist literature, authority topples from its position of unassailability, and tends to emerge as weak and corruptible. Life is worth living, not for the sake of deity, virtue or after-life, but for its own sake, for its own intensity, its own experience of feeling and being. My opinion is that the existentialists performed a valuable service in starting to free contemporary thinkers from the shackles of philosophic, ethical and religious systems that were keeping scientists and laymen alike from seeing man more clearly and more realistically. On the other hand, they seem to have had one major bias of their own; their bitter 20th-century disillusionment, which creeps into their view of man. Most of the existentialist descriptions of life are so terrifying that one feels like congratulating those poor souls who braved survival at all. In some ways I believe the existentialists were busy fighting a feeling that it might be better to be dead, and that this preoccupation with the question of the worthwhileness of living may have caused them to neglect some other aspects of being alive.

This brings me now to my main point: that instead of looking elsewhere, to other cultures and other centuries, we might more profitably look at our own approaches to psychoanalytic therapy in order to locate the origins of our uncertainties, and then discuss how we might resolve them.



A major source of confusion, it seems to me, is that we have been expecting too much from the concept of interpersonal relations. It is of course the hallmark of the Sullivanian school. We know its historical importance, how it liberated psychiatric thought from the early mechanistic picture of a human being unfolding and developing apart from other human beings. We know too its usefulness as a concept showing the reactions of the child to significant figures, as the basis for the formation of the child's personality and his later patterns of relationship to other people. We also know Sullivan's theories about the self, the self that reacts to the stimuli from other persons, and the self-system.

But somehow, it has seemed to me, the emphasis in our teaching and speaking about patients has been placed primarily upon the quality of interpersonal relations that have influenced a patient, on the quality of interpersonal relationship that he brings about, or that he must deal within his present life. It seems to me that we have been too prone to deal in the therapeutic situation with the interpersonal relationship as such, instead of coming to grips with the man and especially with his picture of himself. I am not implying that this is Sullivan's original conception; I do imply that somehow, with the passage of time, the emphasis has shifted, and that as a consequence our understanding of patients and our therapy of them has suffered.

The fundamental force that accounts for behavior and interpersonal relations of any kind, I feel, is really the quality of feeling within the self, about the self. No amount of description, discussion or explanation of interpersonal relationships can possibly be therapeutically effective until we have understood the meaning of the interpersonal relationship to the self. We must first understand and relive the patient's tensions and

distresses connected with his own self-picture. The same interpersonal facts can take place among ten very different persons, each of whom may interpret and react to them differently, in terms of the particular self-picture that he has.

Though I feel we are correct in seeing how interpersonal relations originally affected the self-picture, I believe that too often we mistakenly assume that when the "right" interpersonal relations have been restored, the self will also find itself changed and restored; therefore we concentrate upon the behavior of the individual rather than upon his feelings about his behavior. I believe we do not reach the core of a person as long as we deal mainly with what is going on between him and other people; we really touch him, the human being, only when he tells us how the interaction is affecting him.

For example, in treating a patient's hypersensitive reaction to criticism, how frustrating it would be both to the patient and ourselves if we centered our interest chiefly on the critical quality of his friends, or his irritating effect upon his friends, or why he happened to choose such friends. Not that these considerations are irrelevant, since often they contain necessary pieces of information. But they are not the basic issue. Discussion of such issues does not relieve the patient's hypersensitivity to criticism. It could hardly be considered adequate therapy if the net result of the discussion were merely that the patient sought an entirely new group of friends who were never critical, or withdrew from people once he discovered that they could be critical. Clearly it would be preferable to make sure that the patient understands that all human relationships involve criticism at some point, sometimes justifiable, sometimes not, and that his problem lies in the ways he reacts to criticism of himself, and

how he copes with it. Whether he can tolerate it, refute it, ignore it or profit from it will depend upon the effect of criticism upon his self-system. His first task must be to determine his own subjective reaction. What does criticism mean to him as a person? Does it destroy his self-esteem completely? Does he become frightened? If so, of attack or of abandonment, or what? Does he become paralyzed with fear or anxiety? How can he help but feel unfriendly toward his critics as long as criticism affects him in this particular way? How could he possibly appreciate the friendly, constructive intentions of some critics as long as he over-reacts to criticism with total loss of self-esteem?

In my own experience I have found it unrewarding to approach the problem by dealing with the content of the criticism, or the quality of the interpersonal relationship with the critic, until *after* there has been some resolution within the patient of the specific meaning to him of criticism in general. Later we take up the special meanings to him of certain specific criticism. After his painful subjective reactions to criticism have been relieved, then I often find that the patient's interpersonal relations improve spontaneously, without specific notice, teaching or advice from me.

Most patients, I believe, have quite good pictures of what constitute desirable interpersonal relationships; they have been exposed to the same educational forces in the atmosphere as we. They do not behave in poor or strange ways for lack of education or models; quite the contrary, they often regard our references to desirable modes of relationship as sermonizing or patronizing. They come to us, not necessarily to be taught what patterns of living to follow, but mainly to find out what is obstructing them from living in the ways they know about and really care about.

Moreover, when patients first come to us they generally already have a rather high degree of feeling of inadequacy. If we urge them to behave in a way at which they have already failed, we merely add to their self-criticism, feelings of inadequacy and discouragement. Instead of asking what is wrong with our telling them how to behave, they tend to interpret our misplaced teaching as further confirmation of their wrongness or lack of worth. In other words, by appealing in this way to their conscious standards, actually we further depress their self-picture. Dynamically, such lowering of the self-esteem leads away from change or progress, toward irrelevant argumentation, despair, rejection of psychoanalysis, hyper-criticism of friends and self, and exacerbation of compulsive behavior. As we know, the self with the lowered self-esteem will become busy defending itself from further hurt, not with improving interpersonal relations.

Another example of misdirection of our emphasis and attention is shown in the discussions about love and loving relationships which not infrequently tend to occur early in a patient's treatment. The patient may tell the analyst that he does not feel sufficiently loving, that this is his problem and it is this that he wants treatment for; the analyst may comment to the patient in similar terms. To accept this problem at its face value, to my way of thinking, is to set the stage for therapeutic uncertainty and confusion of both analyst and patient. For by implication it suggests that in order to be mentally healthy it is necessary to be loving. How psychologically realistic is this? Are there not times when being loving is inappropriate or actually dangerous? Or, from another angle, is it necessarily a sign of intrinsic inadequacy in the person that at this current point in his life he is not yet able to feel loving? Need he feel



ashamed and apologetic about it? Or is it perhaps realistic and appropriate that a person with his particular background and his history was deprived by fate of those experiences through which he might have emerged a different person. Too often the patient is one who takes the blame for failing entirely upon himself, and develops the fear that he is not even worthy of being loved. It is this fear of being unworthy that can prevent him from offering his love to others, rather than any intrinsic inability to love. When he is relieved of his self-blame and his conviction that he would necessarily fail again, he will find his way to a loving relationship because he himself not only desires it but has become free to do so.

To carry this example one step further in order to illustrate psychological realism in approaching therapeutic matters, there is the vitally important matter of timing. It is a hard fact but perfectly true that at a certain point in time a patient may not be able to love, despite his wish and the analyst's hope for the loving potential to be liberated. It may be quite impossible at that particular point in their work together, simply because the patient has not reached the stage in his development where he would be ready for or receptive to such a relationship. An understanding by the analyst of developmental readiness can make all the difference between a patient dissatisfied with himself because he has not reached a stage that he in reality should not have reached yet, and a patient satisfied with his current achievements thus far and thereby encouraged to try for still greater goals of self-realization.

I have the impression that we do not view patients enough from the point of view of their own longitudinal development. We do this automatically when we think about children, perhaps thanks to the work of

such people as Gesell and Ilg, who have accustomed us to concepts of growth and maturation in both physical and behavioral terms. In general, psychoanalysts have not paid enough attention to the table of psychological development first presented by Erik Erikson in his *Childhood and Society*, with the well-known diagram beginning with the stage of trust, moving through autonomy, initiative, etc., to end-stages of generativity and integrity. It is not his list or his definitions of particular stages that we need to take literally, but the basic concept of a natural sequence of personality development, no advanced stage of which can develop successfully if there is any serious disturbance, uncorrected, in a preceding developmental stage.

We psychoanalysts must make it our job to determine as early as possible in treatment where each person is on his own developmental line and which essential phase of his developmental line has become twisted up or knotted. For example, if a new patient pleads with us to discuss her questions about sexual relations, courtship and marriage, we should make every effort first to assess her psychological readiness to take up these questions. If we should discover that she has always been plagued with a feeling of physical and intellectual helplessness, has resultant overwhelming feelings of dependency, and has always resented people in general because they have not taken care of her as she thought necessary, we are likely to conclude that her psychosocial immaturity must be taken care of first. And we would feel it sounder to point out realistically—that is, therapeutically—that we do not deem her ready to cope with these matters until she has resolved some more fundamental ones. We do not find fault with her for not being ready to discuss other matters yet; on the contrary, we must indeed give her credit for having been



able to manage other aspects of her life as well and constructively as she has, considering the enormous handicaps under which she had been functioning. She can also be pleased with herself for asking for help when she must have hated to reveal her feelings of helplessness, and can be proud for postponing issues that must seem quite urgent and vital to her self-esteem. To learn that the analyst expects her to be able to tolerate this waiting may be therapeutic in itself since it implies his faith that she possesses this capability, although in her picture of her helplessness she might never have thought so. In this way the stage is set for realistic therapy—refusing to work at a level too advanced for the welfare of the patient, no matter how much she insists; instead, increasing her self-esteem so that she can accept the delay, even so far as accepting what she might at one time have considered to be humiliating. For if we do not succeed in maintaining the self-esteem of the patient at every stage in therapy there is grave danger of losing the patient's willingness to cooperate in the self-revelation that is necessary for further improvement.

I believe we shall all have to come round to thinking in much simpler concepts as therapists than we have been accustomed to so far. We have come into the practice of therapy at a particular time in history when the doors to the wonders of psychology have only recently been opened, when the world in a manner of speaking is still gaping and when, as usual, too much has been promised too soon and much too much is being asked of psychoanalysts by people in general and regrettably by psychoanalysts too. Many analysts, I am afraid, have been expecting the impossible from psychological therapy. One might say that they are attempting to be plastic surgeons of souls. To approach a human patient with such a concept of

therapy not only grossly overestimates what we can actually do, but also maligns the basic concepts of therapy as we know them in the field of medicine: realistically, the doctor who treats a wound can never forget that he is but an assistant to nature, that his function is to learn first the properties and physiology of tissue, then the nature of healing, the conditions under which healing will proceed, the conditions which would interfere with it. Through all the means at his disposal he tries to provide the atmosphere, necessary tissue sustenance, guidance and protection that will liberate the healing forces of nature. He does not direct nature, as some psychoanalysts have been asked by our times to do. He studies the ways of nature, and he assists her.

I feel strongly that a large measure of insecurity and dissatisfaction among today's psychoanalysts may be traced to too heady a dose of psychoanalytic ambition, not enough emphasis on the natural difficulties in producing psychiatric change, and not enough solid foundation in the study of human nature and psychology.

If you were to ask me now, what do I recommend that we psychoanalysts study, I would start with a list something like this:

First, we psychoanalysts could become acquainted with the current exciting work in the field of animal behavior, as represented by Lorenz and Tinbergen in Europe, Schneirla, Liddell, Hess and Lehrman and others in this country. In particular, I think analysts would do well to read carefully the works of Beach at Yale and of Blauvelt and Richman at Syracuse.

Beach, for example, demonstrated the important point that a traumatic incident, so-called, may have extremely variable effects, from great to small, depending upon the previous history of the animal, the age at which the incident takes place, the relationships of the animal at the time it takes

place, as well as the quality, quantity and duration of the traumatizing. This is another way of indicating that it is not necessarily the real fact which is so telling in a human being's life, as its significance to him in terms of his past experience and present situation, the events going on in his life when it happens, and how well he has been able to cope with the traumatic fact.

Blauvelt's work on the relationship between mother-goats and their kids demonstrates superbly (as did also the work of Rene Spitz) the vital biological role of dependency. When the link between mother and kid is interrupted or even interfered with in the experimental situation, the young kids soon become ill and die. One needs no more than this to acquire a deep appreciation and respect for dependency needs in childhood, the powerful reactions to threats of loss of dependency, and the amazing efforts that children make to retain the relation while they need it.

Blauvelt and Richman are at the present time carrying out similar studies on the relationship between human mothers and their babies. This new work has already demonstrated the important point that instincts do not necessarily make it possible for nature to function smoothly from the start. Even in such an instinctual matter as nursing, both mother and infant need anywhere from two to five days of practice until their instincts can function smoothly and reciprocally together. The films showing the behavior of nurses in response to mothers and babies who are in the midst of working out the nursing relationship, and especially the nurse's responses to the anxious mother, make it especially clear that the therapeutic attitude is one that primarily relieves the mother's sense of failure, teaches her what to expect, permits her to discover her own rhythms and to feel capa-

ble in her own way of interweaving her rhythms with those of the baby. Blauvelt's work also shows that the least therapeutic method directs attention away from the real happenings between mother and infant by stressing an ideal interaction, which interferes with the natural process that is taking place and thereby deprives both mother and child of the trials and joy of the mutual activity.

It would no doubt please Harry Stack Sullivan if he could see that his basic theories about development via interpersonal relationships is finding such confirmation today in these experiments. We who follow him can be grateful to the animal psychologists for calling to our attention natural units of behavior which can be observed and studied easily, natural units of behavior which are equally applicable and useful in our own daily work with human beings. Dr. Blauvelt's descriptions of interaction are a model of non-teleological observation, which is always difficult to accomplish. Trying to follow her example could be of tremendous assistance in trying to see and to think clearly about the highly complex individual and social situations that we try to analyze.

There is also much for us to learn from the field of education. In the eager pursuit of the well-adjusted personality, with the eye too much on the end-result or goal, psychology and psychoanalysis, I feel, have tended to ignore basic units of behavior, basic processes which now need to be re-itemized and re-viewed. For some twenty years John Dewey has been out of fashion, but I think it would be profitable for all of us to re-read him from time to time. He was a contemporary of Freud's who really reads like a contemporary of our own. He bears re-reading especially for his perceptiveness about the elements of learning behavior and their larger relationships to life.



We might profit far more than we do from the research of Piaget on the nature of children's thinking. Without his work I for one feel that I could not have understood as well the seemingly fantastic interpretations and distortions that children normally make and unfortunately often carry along into their adult lives.

Lois Murphy's study of the development of children likewise seems to me a happy way of identifying the component parts and patterns in human educational development, making it easier for the analyst to observe the often relatively simple process underlying a complex adult interaction pattern.

To illustrate what I am referring to in the work of educators, we might take up the behavioral unit of "getting." To get, to fill a need, is the first ability every organism must learn. The appetitive drives form the psychological basis of both individual and social life. Considering the disrepute into which the appetitive "selfish drives" have fallen in western culture, it is remarkable how much man has managed to learn about his needs and how to meet them. In this regard the twentieth century has begun to reverse the trend. Thanks to the studies of Pavlov, Cannon and their successors, we know much more now about biological reactions to frustrations of appetitive drives, and about fear and rage.

It has become clear that one's psychological development begins in terms of getting and in receiving, that each human being goes through the pleasure of success or the tensions and frustrations of failure in getting. The first learning is in connection with getting. The first friendly feelings toward other people are usually in response to having been given to, the unfriendly toward those who refuse to give. The management of the natural reaction to frustration becomes just as essential to the develop-

ment of the growing, learning organism as the learning of the capacity to get. You all know the significance for the child who has not learned that frustration will pass, or that his frustration is a normal though difficult experience, who experiences his own frustration as indicating weakness or inferiority in himself, who does not know when to accept frustration as final, or when to refuse to surrender to frustration. You know that the feelings of a child about his ability to get will have enormous bearing on his future feeling of capability and optimism; you know that what a child experiences in connection with frustration early in his life will have much to do with his future capacity to tolerate frustration when it is necessary or unavoidable. The early lessons about frustration bear a close relationship to the child's subsequent attitude towards authority-figures, and the child's own later capacity to assume authority over others. The variable effects of timing of early frustrations, quantities and objects of frustration, and the relationships to the people causing the frustration have great significance for the future inclination of the child to give to others, to expect and receive from others—in fact, whether or not to have anything to do with other people.

It is this kind of psychological function—reactions to getting and not getting—which need to be studied in full, and to be understood in this manifold determining relationship to mental health and mental illness.

The reactions to getting and not getting lead quite naturally into another frequent pattern of interpersonal relationship, the tug-of-war of getting, giving and refusing that may unfortunately develop into the pattern of parental inconsistency and tantrum behavior: uncertainty by the child as to what the parent really intends to do, pushing and testing by the child, angry sur-



render by the parent, ending perhaps in victory for the child but without joy in the getting.

Or again, starting with the fundamental psychological unit of getting and receiving, we can set out to describe how expectations arise, what expectations are regarded as normal, what happens when expectations are not met, the origin of the feelings, "This is not fair, this is not just," or "If you don't give me what I expect, you do not care for me," or "If you do not give me what I expect, then I must not be good enough," or "If you do not give me what I expect, then you are bad and you must be punished." With such building-stones we can also begin to explain neurotic needs, needs that do not spring from expectations based upon experience but arise from deficiencies in the self-picture.

There is also considerable room for clarification today of the real meaning of anxiety, a keyword in psychoanalytic thinking. Our thinking about words like tension, stress, apprehensiveness, fear and anxiety has not always been concrete or precise. Yet these words need to be given specific definition, so that analyst and patient can identify these feelings accurately, so that patients can incorporate the feelings into their daily living, use them constructively, tolerate them where necessary, or relieve them when possible. I personally am inclined to use the word "tension" in connection with unresolved action still in progress, or contradictory tendencies not yet resolved. I use the word "stress" in connection with the psychological and physical cost to the human being of tension and anxiety. I incline for my own purposes to use the word "apprehensiveness" to mean the anticipatory dread of the outcome of the unresolved. And I have come to use the word "anxiety" in a restricted sense, as the psychological

and somatic accompaniment of an unsatisfactory picture of the self.

These distinctions are practical both in aiding the patient and in giving the analyst a firmer sense of direction in his strategy with the patient. Tension can often be borne better when people know that it is normal and expectable in a situation. Experience of stress and knowledge of its consequences provide additional incentive to a patient to make progress. Apprehensiveness is sometimes entirely appropriate and it is often important chiefly to help patients to know how well they will be able to function despite their apprehensiveness. As for anxiety, I have noticed a marked change in my own sense of security in dealing with patients since I have relinquished the antiquated concept of a free-floating anxiety, unrelated to one's body, one's self-picture, or one's relationship to other people. I am not inclined to believe that there exists any anxiety without cause. Usually I have found it valuable to learn more about the patient's situation, his reactions and interpretation of it, especially in terms of its effect upon his picture of himself and his welfare.

Continuing with suggestions that may be of help to psychoanalysts in attaining psychological realism, I feel a word about the use of anthropological studies are in order. We need more familiarity with the idea of culture—the group of conventions and patterns around which a group organizes its relationships, its communal living, its expectations, those aspects of life it over-values or under-values, and those aspects of life it provides for or prohibits. We need to be quite clear about the overlapping between culture and the individual, to be able to recognize where the individual has indeed been influenced by his culture without being aware of it, or where the individual uses his culture to hide behind in

justifying behavior which really is of subjective origin.

We have probably not made as much use of anthropology as we might since most of it has been written about tribes so remote from us in time and cultural patterns that we have found it difficult to extrapolate. Yet there now is available knowledge of a few selected modern cultures which are important to know about because of the marks they have left on our own conglomerate cultures in the U.S. Today's psychoanalyst, especially if he is working and living in New York, could feel far more certain about meanings and origins of behavior patterns he is asked to deal with if he had obtained a working acquaintance of cultural patterns in the British Isles, Germany, Italy or Spain, the post-slavery Negro family, and the *steil* culture of East European Jewry. Those of you who have already read the delightful book *Life Is with People* will know how infinitely useful it is for comprehending Eastern Orthodox Jewish culture.

In my own experience I have found that familiarity with at least one Slavic or Far Eastern culture is especially valuable in helping to free oneself from the tyranny of one's own unconscious cultural heritage. I should like to recommend at least one good course in comparative religions, for the same reason.

Last on the list of newer understandings that I feel might help to dispel therapeutic pessimism is the considerable amount of new information and interpretation offered in the area of interpersonal communication.

Communication, at its simplest, is how patients talk to us and how we talk to them. Much time is spent during our training as psychoanalysts on the history of psychoanalysis, the critique of psychoanalytic theory, personality structure and dynamics—all of which are necessary—but we spend

proportionately far more time on them than on a very important course called simply "the initial interview," which in my opinion is vital to the training of an analyst. In it we get our basic notions about the necessity of observing and drawing some meaning from the finest occurrences, the slightest motion, the stance and gestures, the tone of voice as well as the words, spoken and unspoken. In this same course we also begin to learn the strategy of therapy, which must consist of what one says, how one says it, and what one does not say. In my opinion, it is a course that should begin in the first year of an analyst's training, should continue through each year of his training, and perhaps continue for some ten years after he has graduated. It should move on from the initial interview to the first month's interviews, interviews at times of crisis, interviews at times of lulls, interviews at times of progress, and so on till finally we come to interviews relating to the termination of therapy. There are many regularities in the natural growth of the psychoanalytic situation that could well be taught in class or seminar fashion, and that could include more of the modern knowledge about linguistics, kinesics and non-verbal communication.

It also seems to me that there is much more we can be taught about ways of *hearing* what the patient is saying, about different awareness of his sentences, what parts of his sentences and paragraphs to listen to. We could learn much more about what to expect, so that we could become more quickly aware of what is being omitted. No doubt we could also greatly shorten the time that therapy takes by increasing our efficiency in hearing what the patient is saying, and by increasing our competence in saying to him what will really help him more immediately. The

art of talking with patients can be better understood, better explained, given a more secure foundation that will support the psychoanalyst while he is working with his patient.

In conclusion, my last thought about therapy today is that most of us are trying to accomplish more therapeutically than we as a profession are ready and able to do. Undoubtedly we are overreaching ourselves, trying to achieve more than we know, denying ourselves the time in which to acquire from other areas of knowledge the very things we need.

It is often a very difficult profession; yet it has its rewarding sides. It gives us the opportunity to know many lives in three

dimensions, to learn much about human beings, to help some of them with their problems. With many of our patients we can feel adequate and we can be pleased with them and with ourselves.

We necessarily complain about the many uncertainties under which we work. No matter how many of these uncertainties we clear up, there will certainly be more for a long time to come. It may be that as therapists we shall have to reach our own maturity in order to be able to tolerate our own special forms of incompleteness and uncertainty. As we become less anxious ourselves about uncertainty, we shall be freer to see our way in therapy more surely.



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PAUL HAUN, M.D.

# Attitudes about mental health

## A cultural and psychodynamic appraisal

It would be a somewhat thankless task to add to the collection of statistics designed to show that the general public is skittish about mental illness, and that a distressingly large proportion of professional people share its views. If we are willing to accept this unpleasant fact as already demonstrated, we are free to speculate on why a few general practitioners of medicine display such alarming ignorance of mental disease, why little boys continue to scare each other by peeking into the windows of psychiatric hospitals, why a Broadway comedy can scarcely hope for success unless it has a few jokes about psychiatry, and why our friends and neighbors grumble about going into the hospital for an appendectomy but sink into soul-wrenching terror at the thought of a mental illness.

There is, I fear, no documented explanation for these sorry facts—no certain answer

to the questions that they raise. A conjectural inquiry may, nonetheless, serve a useful purpose if it helps us recognize a new dimension of reality, and assists us in channeling some of our efforts in more promising directions.

I was vacationing at a remote but in no way inaccessible region of the mountains when I met George Hicks. He was a slight, wiry man in his middle fifties who worked in a small furniture factory tucked away among the pine trees. His home was comfortable although it lacked what we nowadays tend to expect in the way of electricity, plumbing and central heating. He and his

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Dr. Haun, who is director of psychiatric education for the New Jersey Department of Institutions and Agencies, presented this paper October 30, 1958 at the 57th annual conference of the New Jersey Welfare Council.

wife worked their acre or two of ground less as a farm than as a kitchen garden and were able by this means and the exercise of reasonable thrift to stay out of debt and to own a second-hand car and decent clothes. George liked to hunt and fish but was not interested in travel for its own sake and had visited the county seat, a town of some 12,000, only twice in his life. He and his wife, members of the same church attended by the majority of their acquaintances, liked to visit their neighbors and have friends drop in for an evening's sociability.

George had stopped school in the fourth grade to help his father clear a piece of land and had never found the time to go back. He knew all the arithmetic he needed for his work in the furniture factory and for his occasional purchases at the store. He could read, although he habitually formed each word with his lips and kept his place on the page with a forefinger. On the infrequent occasions when he was obliged to sign his name, he did not write it but would draw it clearly and carefully like a picture. He was a dependable, careful worker who got on well with most people. Now and then someone asked his advice, and his opinions were usually respected.

The thing about George, however, was that he believed the world was flat. He had never mentioned it to me and felt no compulsion to persuade others to his view. It came out only after I had known him and his fellow workers at the factory for some little time, and they had gradually discarded some of their company manners. A rather disagreeable young man who enjoyed needling George whenever an opportunity occurred came out with it abruptly one day. George shot a lightning glance at me, ready to run for cover, while the young man who had been his tormentor prepared for a loud guffaw at George's expense. I must have been able to react in much the

fashion that would have been expected had I been told that George was fond of cucumbers, because when I asked him how he had come to this conclusion he answered me candidly and quite adequately.

Mountain crests were obviously higher than valleys. Up was up and down was down. If the world was a sort of glorified baseball, it had a top and a bottom. It had up and it had down. It simply went against a man's daily observation that water could be made to run uphill. Unless the world was flat, all the water in the streams and in the oceans would naturally follow the laws of up and down and drain away something in the fashion of the Sherwin-Williams trademark in which big globs of paint are pouring down the sides of the earth and dripping off the bottom. To George the horizon was not the point at which the curvature of the earth became manifest. It was simply the limit of human vision. However far he had walked on his hunting trips, he had seen nothing spherical about the ground beneath his feet and every stream had obviously run downhill.

How about circumnavigation though? Didn't that put his theory in question? George grinned at this, and it was clear that he was still on familiar territory.

Here he was open-minded and felt that there were two possible explanations. First of all, it was hearsay. No one of his acquaintance claimed to have sailed around the world, and George had heard enough fish stories in his life to know that men were not above pulling your leg with a tall tale. He leaned more, however, to the thought that these people were self-deceived and that they had actually mistaken a circular journey on a planar surface for circumnavigation. Those who affirmed that the world was a baseball were stuck with the conclusion that China was directly under foot and, as a consequence, that Chinamen

walked upside down—a bit of nonsense which stirred George's risibilities.

It would have been easy to think of George as a fool or, at best, an eccentric. Yet there were certain uncomfortable consequences to this conclusion. In historical perspective a high percentage of humanity would have had to be lumped together as buffoons, including Sophocles and Alexander the Great, Mohammed and Julius Caesar. As late as the sixteenth century there were plenty of competent navigators who if they ventured too far from land were by no means sure that their vessel might not slip over the edge of the world into the measureless void beyond. In fact, I think we will have to give George credit for a greater measure of native intelligence than his tormentor. He came to an unfashionable conclusion based on a careful scrutiny of everything he was able to observe, of every fact he had at his disposal. His tormentor simply accepted the conclusions of other people without the vaguest understanding of how they had been reached. We'll return to George a little later.

I would now like to interpolate two pertinent passages from *The Witch's Hammer*, a book written by two Dominican inquisitors accredited by Pope Innocent VIII. It was first published in Cologne in 1489. Fourteen editions had been issued by 1520, and another 16 between 1574 and 1669. It was a sort of inquisitorial Blackstone, a handbook to which for some 200 years pontiff and king, bishop and judge made constant appeal in their struggle against witchcraft. How did Pope Innocent see the threat? In his Bull *Summis Desiderates* he says:

"It has indeed lately come to our ears, not without afflicting Us with bitter sorrow, that in some parts of Northern Germany, many persons of both sexes, unmindful of their own salvation and straying from the Catholic Faith, have abandoned themselves to

devils, incubi and succubi, and by their incantations, spells, conjurations, and other accursed charms and crafts, enormities and horrid offences, have slain infants yet in the mother's womb, as also the off-spring of cattle, have blasted the produce of the earth, the grapes of the vine, the fruits of trees, nay, men and women, beasts of burthen, herd-beasts, as well as animals of other kinds, with terrible and piteous pains and sore diseases, both internal and external; they hinder men from performing the sexual act and women from conceiving, whence husbands cannot know their wives nor wives receive their husbands; over and above this, they blasphemously renounce that Faith which is theirs by the Sacrament of Baptism, and at the instigation of the Enemy of Mankind they do not shrink from committing and perpetrating the foulest abominations and filthiest excesses to the deadly peril of their own souls, whereby they outrage the Divine Majesty and are a cause of scandal and danger to very many."

The book deals exhaustively with every problem, with every difficulty that could be foreseen, discussing it, resolving it. Part One treats of the three necessary concomitants of witchcraft, which are the devil, a witch and the permission of Almighty God. Part Two treats of the methods by which the works of witchcraft are wrought and directed, and how they may be successfully annulled and dissolved. Part Three relates to the judicial proceedings in both the ecclesiastical and civil courts against witches and indeed all heretics.

In a chapter dealing with some of the more distressing examples of witchcraft we find the following case history. The authors write:

"A certain high-born Count, in the diocese of Strasburg, married a noble girl of equal birth; but after he had celebrated the wedding, he was for three years unable



to know her carnally, on account, as the event proved, of a certain charm which prevented him. In great anxiety, and not knowing what to do, he called loudly on the Saints of God. It happened that he went to the State of Metz to negotiate some business; and while he was walking about the streets and squares of the city, attended by his servants and domestics, he met a certain woman who had formerly been his mistress. Seeing her, and not at all thinking of the spell that was on him, he spontaneously addressed her kindly for the sake of their old friendship, asking her how she did, and whether she was well. And she, seeing the Count's gentleness, in her turn asked very particularly after his health and affairs; and when he answered that he was well, and that everything prospered with him, she was astonished and was silent for a time. The Count, seeing her thus astonished, again spoke kindly to her, inviting her to converse with him. So she inquired after his wife, and received a similar reply, that she was in all respects well. Then she asked if he had any children; and the Count said he had three sons, one born in each year. At that she was more astonished, and was again silent for a while. And the Count asked her, 'Why, my dear, do you make such careful inquiries? I am sure that you congratulate me on my happiness.' Then she answered, 'Certainly I congratulate you; but curse that old woman who said she would bewitch your body so that you could not have connexion with your wife! And in proof of this, there is a pot in the well in the middle of your yard containing certain objects evilly bewitched, and this was placed there in order that, as long as its contents were preserved intact, for so long you would be unable to cohabit. But see! it is all in vain, and I am glad,' etc. On his return home the Count did not delay to have the well drained; and, finding the pot, burned

its contents and all, whereupon he immediately recovered the virility which he had lost. Wherefore the Countess again invited all the nobility to a fresh wedding celebration, saying that she was now the Lady of that castle and estate, after having for so long remained a virgin. For the sake of the Count's reputation it is not expedient for us to name that castle and estate; but we have related this story in order that the truth of the matter may be known, to bring so great a crime into open detestation."

As with George, who believed the world was flat, it is easy for us to feel a shocked abhorrence at a society which believed in demonic possession and burned miserable old women at the stake because they had been declared to be witches. Yet suppose, for the sake of argument, that witches do exist, that they do cast evil spells upon the innocent and are the proximate cause not alone of a vast amount of human misery, but of the eternal damnation of countless souls who, throughout eternity, will be doomed to unspeakable punishment. Would we not feel a pressing need to combat this terrible threat and to eradicate it root and branch? Would not our humanitarian consciences compel us to be exquisitely cautious in all that we undertook so that no innocent person was mistakenly punished, no hysteria created, no venal motives countenanced? It will interest you to know that this is the consistently reiterated theme of *The Witch's Hammer*. The sober and consistent insistence of its authors—Do not be impulsive! Make no mistake! Destroy only that which is surely evil! Grant only the basic assumption that witches exist and all the rest becomes necessary for the preservation of humanity. We will return to *The Witch's Hammer* a little later.

Having jumped from a hillbilly who believed the world was flat to medieval witchcraft, our next speculative flight is to the

comfortably rational year of 1898 and the publication of a novelette by Henry James. He came from a remarkable family and, through long association with his brother, William James, distinguished educator and psychologist, became interested early in his career in the quirks and oddities of personality. Dry facts uncovered in William's careful scientific investigations were seized upon and transmuted in the cold flame of Henry's artistic genius into quite remarkable works of art. The little book he published in 1898 called *The Turn of the Screw* is an exquisitely precise invocation of terror, a clinically exact anatomization of its specific qualities. I challenge anyone who is capable of having a nightmare to read it without experiencing a first-class attack of the creeps. Even to think of the children, Miles and Flora, of Miss Jessel and Mrs. Grose, or of red-haired Peter Quint is to feel our hearts begin to thump and our hair to prickle.

James' success in writing what to many of us is the one authentically terrifying book in the English language is reducible to a quite simple technical device. By his skill as an author he persuades us to believe in the reality of the people and the events he describes. He then whispers a hundred clues which might account for the whole affair and masterfully avoids weighting any of them in a fashion which would clarify the matter or cancel out all of the remaining hints. We are left to flounder helplessly from one speculation to another, each more horrifying than the last, and to find that none has sufficient solidity for us to feel that, bad as it is, we understand at last. For the time that we are under his spell, James compels us to face the unknown, the inexplicable, the incomprehensible, and it is this which is the essence of terror.

Each of us is born with a set of needs which must be met if we are to survive.

Most of these we share with other forms of mammalian life: the need for air to breathe, for a degree of warmth, for food, for water, for sleep. None of these is peculiar to our species. Surprisingly enough, there is another need which is seldom mentioned, perhaps because it is so basic that it has escaped our attention. Although it is essential for human development, I would suspect that it is in or near awareness only among human beings. In this sense, it distinguishes the human organism from all other forms of life. Quite simply and quite obviously, it is the need for order, for a measure of predictability in ourselves, in our physical environment and in our relationships with other beings. In this frame of reference, man's entire existence from birth to death is an uninterrupted sequence of educational experiences. The initial lessons concern the difference between a leg which is attached to my body and a rattle which is interruptedly attached to my hand; between a noise and a mouthful of milk; between a mother and the odor of soap. Many years later the lessons may concern the difference between a proton and an electron, or between a note delivered through official diplomatic channels and an inspired editorial appearing in a government-controlled newspaper.

If the infant's hand became first a teddy bear and then a doorknob, and the next instance a noise of ringing bells all in a completely capricious and altogether unpredictable fashion; if all mothers were werewolves, now a bat, now a mote of dust, now the rustle of autumn leaves; if electrons obeyed no discoverable law and nations acted in a manner which could never be defined as probable or improbable, we would have arrived at chaos—and no human being can survive in chaos.

Although the examples I have used are extreme to the point of irrationality, they



illustrate the essential nature of the principle. When the titre of uncertainty in existence rises too high, human life becomes impossible. We walk confidently in the daylight because our past experiences which began in infancy and the stream of visual stimuli impinging on our brain assure us that the sidewalk will be solid beneath our feet. We grope and shuffle in the dark because we cannot predict what lies ahead—a precipice, a wall, or a highwayman.

If I believe my friend when he tells me that I am in the center of the Bonneville salt flats and that the ground is entirely without irregularity beneath my feet for miles in all directions, I will consent to run, tightly blindfolded, at top speed for whatever distance my wind holds out. This is faith which, in our search for order and predictability, is quite as serviceable as any other kind of evidence.

We are ready now, I think, for the conclusion. George Hicks needed a picture of the world in which to orient himself. The threat of slipping off a terrestrial sphere into free-floating space flight seemed, according to his best judgment and the direct testimony of his senses, an imminent possibility if the world was not comfortably flat and correspondingly stable. He felt insecure and doubtful with the one theory, comfortable and content with the other. His need for order and for predictability was answered if he accepted what clearly appeared to be the fact. He was satisfied with the opinion held by countless generations of his forebearers.

Pope Innocent VIII believed unshakably in witches, as did his contemporaries. Their existence allowed him to remain convinced of God's mercy and goodness. Their evil works explained a large chunk of the otherwise inexplicable. They were the reason why upright men were visited by disaster; why virtue was not always rewarded; why

strange sicknesses attacked, as he says, "infants when in the mother's womb, beasts of burthen, herd beasts, as well as animals of other kinds, vineyards, orchards, meadows, pastureland, corn, wheat, and all other cereals." Belief in witches spared him and all men from a conviction, which in that day appeared as the only alternative, that God had created a capricious, unpredictable and chaotic universe totally lacking in order.

Henry James in his vignette of terror reminds us that we share with George Hicks and with Pope Innocent the same fear of chaos, the same need to have all that touches our lives, categorized by experience, by reason or by faith as somehow, somehow susceptible to law; obedient even though obscurely to the dictates of order.

This, I suggest, may explain to some degree our queasiness about madness; our difficulty in accepting the mentally ill as ordinary folk victimized by their genes, or their environment, or their metabolism. Until day before yesterday leprosy gave everybody an attack of supernatural shudders because we were quite unable to understand it. Until this morning epilepsy was the divine disease, quite unsatisfactorily explained by a mishmash of ideas involving possession by evil spirits, prophetic gifts and superhuman strength. Is it then so strange that many of our fellow citizens react with apprehension and anxiety when mentally ill people say unpredictable things, behave in erratic ways, are subject to inexplicable impulses, and make startling demands upon us which we often cannot understand and which appear to have no order about them whatsoever?

In the course of his correspondence with Ralph Waldo Emerson, Henry James, Sr., once wrote: "I am led, quite without any conscious willfulness either, to seek the *laws* of these appearances that swim round us



in God's great museum—to get hold of some central *facts* which may make all other facts properly circumferential, and *orderly*."

The bogeyman who lives in the attic above junior's bedroom is not exorcised by patient explanation and sweet reason. He is routed by father's reassuring presence and by switching on a great many 100-watt light bulbs. Of course, he moves to some other dark and mysterious abode, the hayloft perhaps, or the root cellar, but this is quite another matter. While the lights are on and while father's arm is around junior's shoulder there are no mumbling phantoms crouched on the broken furniture or shuffling among the attic trunks.

The hospital volunteer and the new employee have a similar experience, I would expect, when they enter their first psychiatric ward. It is the light of understanding and the reassurance of experience which soon dispel the imagined terror and in time allow the willing observer to see more and more of the mentally ill, not as unpredictable monsters, but as lonely, suffering and unhappy human beings.

Some mental health education would appear doomed to failure because its naive exhortations are entirely dissociated from

audience experience. It is, I think, akin in its ineffectiveness to a parent's insistence at the dinner table that there are no bogeymen in the attic. Junior simply asks for another dish of ice cream and keeps his own counsel with respect to goblins and their place of residence. Other educative efforts may be less than successful in spite of their unquestioned truth and logical coherence only because they are too fine-spun, too recondite. Their message has yet to be persuasively translated into language that the rest of us can lay hold of, into understanding that we can make our own.

If, as I believe, Henry James, Sr., was expressing a universal human need when he cried out to Emerson for an understandable order in God's great museum, then we whose vocations and interests are in the field of mental health may take comfort in our own insight into what remains about us of social prejudice, public apathy and legislative indifference. With a better understanding of the origin of these attitudes, and of the purposes they serve, we can reflect on the value of our dinner table exhortations about bogeymen, and wisely seek for ever better systems of illumination to push back the darkness.

# Social and emotional development of students in college and university

## Part 1

Attention is being focused today on the college student as never before in American history. Education, science, business and industry, and government services all compete with one another and with other groups for his services. The man or woman without a college degree finds himself at a great disadvantage when it comes to bettering himself in our society. College administrators are staggered by the thought of what they must do to meet anticipated demands of a double teaching load in the next fifteen years.

In times of urgent attention to the demands of millions of students, to raising money and to constructing classrooms and

laboratories, concern with the individual student should not be neglected. Indeed the success of all higher education depends in large measure on how each young man or woman feels about his college experience. It makes an immense difference whether he acquires attitudes and habits favorable to his own later intellectual, social and emotional development as a result of his college experience, or develops anti-intellectual tendencies accompanied by bitterness and frustration.

As our society has become more and more complex the number of choices the student must make becomes greater and greater. As we grow more mobile, more rootless, more urbanized and more dependent upon a web of interdependent technical devices the individual may feel that he has lost much of his significance. As a result he may become an easy prey for those who would exploit him.

Today's student is both fortunate and un-

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Dr. Farnsworth is Henry K. Oliver Professor of Hygiene and director of health services for Harvard University and Radcliffe College. The 2nd part of his paper—covering international interest in the mental health of students and possible future developments—will be published in the October 1959 number of *MENTAL HYGIENE*.

fortunate. Never in all history has he had so much to learn nor so many channels through which he may acquire information. Yet in the major disciplines and professions it is no longer possible to master the factual material. The student can learn how to think effectively with only the material in his area of interest. After he has acquired the basic tools of thought he can then, with appropriate judgment, balance his factual knowledge against his awareness of what he does not know.

This latter ability is more difficult to gain than mastery of factual material alone. It involves the weighing of various alternatives, and a knowledge of himself and the people with whom he is associated, and also the making of choices even when the facts are insufficient for certainty. In short, what we call social and emotional maturity is as desirable as is the development of intellectual power as an end product of formal education. Consideration of the emotions, of feeling, of unconscious determinants of behavior, and of those principles which affect interpersonal relationships are usually accorded only superficial consideration in the educational process. They deserve and require far greater attention.

#### SHOULD EDUCATIONAL GOALS BE BROADENED?

College students are the group from which the great majority of our future leaders will come. It is during their years at college that ideals and identity are largely established and that goals for the future are set up or redefined. Students are more inclined to formulate their ideals and to define their goals on the basis of what they see going on around them than in terms of some theoretically desirable system. What they observe will depend greatly on the attitudes of their teachers and especially on the attitudes of their own contemporaries.

At present there are no clear-cut methods that a college may adopt if it attempts the task of broadening the base of its educational goals to include an understanding of the emotions. Furthermore, there is no general agreement among psychiatrists and psychologists as to how to set up a program designed to increase understanding of personality factors, both of one's self and of others. Some institutions approach the task through the medium of courses in human relations, others through special counseling programs, and still others by way of psychiatric services associated with student health programs.

The crucial element in any educational institution determining the quality of feeling or sensitivity of its students, and their value systems as well, is the attitude of the faculty members toward their students. If teachers and administrative officers convey attitudes of friendliness, warmth and insistence on basic integrity and high intellectual standards to their students the quality of each individual's experience in college is quite different from that of the student who feels that his instructors are aloof, impatient of him and interested only in their subject and private affairs. Contact between students and their elder colleagues as they struggle with attainment of common goals forms the only effective way by which attitudes may be transmitted. There is profound truth in the cliché that attitudes are caught rather than taught.

At this point the complications mount. The demands made upon faculty members are constantly increasing, in part because of the extending borders of all fields of knowledge, greater numbers of students and economic pressures. A teacher who makes a good impression on his students may soon be swamped with personal interviews with them. Being friendly, helpful and willing to listen to their quandaries may result in



undue fatigue and interference with his own professional development. Yet a defense consisting of aloof attitudes, veiled contempt for undergraduates, preoccupation with research, and strained procedures to make himself inaccessible satisfies neither the teacher nor the students. The improvement of the quality of relations between faculty members and students is therefore a more reasonable goal than merely having them spend more time together. The students also have great demands on their time.

In their attempt to develop careful habits of thought and to instill a sense of responsibility and good judgment members of a college faculty are confronted with a vast number of influences that work against them. In our society materialistic notions or standards of success are everywhere emphasized. The man of action is rewarded both in terms of public esteem and in the size of his income. The thinker is often derided. He is the butt of jokes and cartoons and gets, on the whole, little public respect. Originality in thought is misunderstood or misinterpreted, sometimes deliberately. Our mass media of communication overemphasize stimulation, excitement and exploitation of the people, who are as often as not captive audiences—either in fact or by a process of seduction.

College students as they come through adolescence and approach maturity show the end results of the ideals derived from their families and from the church, school and society to which they belong. At the same time they are now in a position to examine those ideals more objectively and to decide whether they are suitable ones to pass on to their own children. This process will occur in a productive fashion only if the college realizes its responsibility in the matter and deliberately tries to organize its educational program toward the develop-

ment of adequate values and attitudes favorable for satisfying and constructive living. If the educational philosophy of the college is based solely on the idea that its function is confined to the transmission and accumulation of knowledge, the formation of ideals and the development of a mature sense of responsibility will be accidental and more incomplete—far more than it need be.

If, on the other hand, a college or university accepts the responsibility of enlarging the scope of education to include the development of self-knowledge and a sense of responsibility, many new procedures will be needed and many attitudes will, of necessity, have to be changed. Instead of assuming that the student has developed responsible and mature attitudes if he has passed his work and has kept out of trouble, positive knowledge of the individual will be needed which can be obtained only by more personal contact between him and faculty members. Counseling will then become a stimulus toward integrity of intellect and character as well as an aid to problem-solving and a vehicle for giving information about courses and careers. The idea of such shifts of emphasis in higher education might be distasteful or alien to those who hold the cloistered study as their sole ideal of the academic life, for to them it would mean a painful re-examination of their own ideals and goals and how they relate to students and teaching.

Just as the knowledge of most teachers about the emotional reactions in their students is somewhat limited, so the knowledge of psychiatrists and their colleagues in related fields about education is far from complete. Psychiatrists are not qualified to come into any educational institution and tell educators what they should do. The most valuable contribution they can make is to work with teachers, deans, counselors,

student leaders and any others who are involved in interpersonal relations on problems in which one or more persons are angry, hurt, rebelling excessively, frustrated, feeling rejected or not working effectively. Every time a psychiatrist and an educator work on a common problem each learns from the other, and attitudes are altered in subsequent situations.

#### BACKGROUND FACTORS IN EMOTIONAL ILLNESS

As the college psychiatrist works with students who have emotional disturbances he is constantly impressed with how many of them originated in the student's earlier life rather than in conditions existing in the college itself. These unfavorable conditions of early life are by no means always inevitable, nor are they mysterious. They can often be modified. They are usually the result of defects of knowledge or character, or both, in the persons with whom the child had his closest personal contact.

Among these unfavorable conditions are included parental discord or conflict, emotional rigidity, intolerance and prejudice in parents and in older associates, lack of emotional warmth in parents and teachers, absent or inconsistent discipline (especially when friendly attitudes are wanting), improper or inadequate education about body functions, and other unfavorable environmental influences. There are, of course, many others, but most of them are derived at least in part from the general ones just enumerated.

#### THE STUDENT'S REACTIONS TO EXCESSIVE CONFLICT

The student concerned with conflicting emotions has a variety of ways of expressing his mixed feelings. Some of these are conscious and their significance is obvious, if

not to him, at least to his friends; but a larger number are not conscious and hence his behavior may not make sense, either to himself or to others. The college junior who suddenly starts making poor grades after two years on the dean's list hasn't "suddenly become dumb," nor is it usually accurate to say that he is lazy. Another student may become apathetic and complain that he cannot make himself want to work. He has dozens of ways of postponing or avoiding work. He plays solitaire, goes to the movies, sharpens pencils, puts his room in order, visits his friends down the hall, plays some records—and still when he starts to study his mind won't do his bidding and focus its attention on the subject assigned. Sometimes he is concerned about the fact that he doesn't care and feels that he never was any good anyway and never will be. At other times he doesn't seem to care about his own lack of concern for his ineffectiveness. He has plenty of intelligence, but it is not at his disposal.

Sometimes a student will shift his worries without being aware of the process in such a way that a physical symptom takes the place of the original problem. Then he and his family can be concerned over the headache, the butterflies in his stomach, the easy fatigability, the fainting episode, or the frequent colds. The baffling thing about physical symptoms is that they may be caused by emotional conflicts or they may have no connection with the emotions at all and be due to an infection or to some other process which has affected some portion or all of the body. To distinguish between the two is not only difficult but at times well-nigh impossible.

An occasional student shows his inability to deal with his personal and private thoughts by escaping into overactivity. He goes out for many organizations and, after committing himself to far too many proj-



ects, overworks himself trying to live up to what is expected of him.

Another may withdraw from all extra-curricular activities or express himself in words or behavior that his friends cannot understand and that do not make sense either to himself or others.

Those who act out their feelings are the most difficult to understand or to tolerate on a college campus. Their attitudes of hostility or aggressiveness, originally generated by something which happened at home or with close associates years before, become displaced onto something or someone in the college environment. They act in such a way as to provoke others to dislike them, they destroy property, they use alcohol quite inappropriately, they criticize others, and in general they manage to lose most of their friends, actual or potential. Yet this friendship may be the thing they most want and need!

Still other students get involved in a series of accidents or mishaps which seem at first glance unavoidable but which on closer inspection are found to be based on hasty and poorly conceived plans of action.

Psychotic breaks, including suicides, occur in colleges with disquieting frequency. A general estimate based on unreported experiences of various college psychiatrists suggests that about two psychoses can be expected yearly for each 1,000 students and that a suicide can be expected somewhat more often than once yearly in a student body of 10,000.

There are many other ways by which a young man or woman in college may show that he is in trouble, but these are enough to indicate that most of them can be recognized and the more important causes can be established.

These background causes are the really important considerations and they are

usually involved with the kind of family from which the student came. In fact, these are so important that it seems to me—and to many of my colleagues who are primarily interested in the development of healthy personalities—that every college student ought to learn sometime in his college course what a good family means to a developing child. If knowing were sufficient, this particular educational device could easily be carried out universally. Unfortunately, learning how to get along with others, particularly with other members of one's own family, comes more from good examples than from precepts.

The college student whose parents have loved him sincerely and frankly, who have taught him wholesome attitudes about body functions, who have retained their ability to see how things look to him, and who have maintained a consistent discipline to which they themselves also adhered rarely gets into serious or long continued trouble. If, in addition, they have encouraged his gradual independence from them by respecting his decisions, have furnished as good home surroundings as possible, and have been patient with him as he worked through his appropriate stages of childhood, his chances of an effective and satisfying college life are still further increased. Such a person is likely to have an affectionate nature with the capacity both to give and to receive affection. He can put up with considerable frustration and an occasional defeat. He can think of others as well as himself and respect them because they are human beings.

Not all students are so fortunate as this ideal one I have just been describing. The student who is struggling with an emotional handicap needs the understanding of his teachers and friends while he is in the process of trying to understand himself. This world has many paradoxes, not the



least of which is why we as people are so afraid of coming to grips with the problem of understanding ourselves. In this respect it is encouraging to observe that resistance of this sort usually comes from people of my generation, not from those of high school or college age. The student approaching college has, as a general rule, an open mind about a number of matters concerning personal development and emotional stability which his elders view with anxiety.

## RELATIONSHIP BETWEEN STUDENT AND COLLEGE

What can a new student do in college that will be of the greatest aid in satisfying accomplishment? How should he think about himself and others? How can he avoid overreacting to events in his own background which may have been unfortunate? How can he avoid becoming so busy that he hasn't time to live?

Colleges are not organized—or at least *should* not be—to fit their students into some type of preconceived mold or stereotyped intellectual and cultural pattern. A student's experience begins with what he brings with him in the way of attitudes, motivation, conditioning and point of view. The college does the best job, in my opinion, when its officials and teachers see it as their function to respect the individuality of each student, recognize his differences, encourage his peculiar strengths and attributes, and give him the maximum opportunity to grow. As Karen Horney has said, you cannot teach an acorn to become an oak tree. At the same time, as these attitudes are being expressed in their direct and indirect teaching, the necessary compromises in group living are being considered in many different ways, so that order may be achieved but not at the expense of conformity, which in itself would not be

conducive to intellectual and spiritual progress.

In this the student himself can help immeasurably by paying some attention to understanding himself. A student should think of college, not only in terms of what it can give him, but also of what opportunities will be his in the way of stimulating and friendly associates, library facilities, athletic and social activities, and possibilities of serving others. Instead of thinking of education as the accumulation of facts and skills, he will think of it as the acquisition and encouragement of curiosity and of that sense of wonder which makes for humility, and as the development of a lifelong attitude of respect for the search for knowledge and truth.

He will not let the few things that are wrong with his college get in the way of using and appreciating those things that are right about it. He will not think of college as preparation for life, but as life itself, the time and place when the tone and standards are set, the social organization in which there is just enough protection to keep him from being overwhelmed and defeated by his own mistakes but not enough to keep him from making his own decisions, good or bad, and seeing and facing their consequences. Undesirable traits or attitudes resulting from unfortunate early experiences can be modified while the desirable ones are strengthened, assuming that the majority of the college faculty and upperclassmen have a dynamic concept of personality growth and a real liking and respect for human beings generally. This is admittedly a large assumption.

## A SIGNIFICANT CASE HISTORY

The experience of a recent student patient illustrates the need for widespread awareness of what may affect the develop-

ing personality of a growing child. This student went to his college chaplain stating that he was having scholastic difficulties. The chaplain recognized immediately that his problem was a serious one and that it was emotional in origin and referred him to the college psychiatrist.

When he came to the psychiatrist's office, he was obviously very tense and talked rapidly about many things in his background. He had been to many different schools and said that every time he was "dumped into a new group" his troubles became more numerous and varied. He had a mild stomach-ache every night when he went to bed.

In his childhood he had feared the dark until he was 15 years old. Because of this, he was frequently allowed into his parents' bedroom where he was made aware of their varied sexual activities. He worried over his own erotic feelings. He became very confused about his religious beliefs. His parents quarreled a great deal, and at various times were on the verge of divorce. Any display of emotion on his part was frowned upon. His mother was indecisive and inconsistent. He gradually learned that if he could get his father and mother into an argument he could get his own way. He then hated himself for his selfishness.

He was sent to a physician who gave him a physical examination. As a result of a basal metabolism test, the physician reported that he was "deficient in energy," to which the patient commented, "Of course, I didn't have enough energy. I was too filled with conflict."

Brief psychotherapy helped him finish the college year with satisfactory grades, but he would not consider intensive treatment. In his next college year he refused treatment altogether, finally withdrew from school, became psychotic two months later,

and then spent several weeks in a mental hospital.

At the time of his psychotic break his parents finally began to appreciate some of the causal factors that had led to his illness. Of these his father wrote, "The whole condition must be due to the emotional adjustment between my wife and myself during his infancy and early childhood. These conflicts, although under some control, did go on, and must have taken their toll on his sensitive and formative mind. There is certainly great lack of understanding in this groping world in which we find ourselves, and there is much constructive work yet to be done. It is indeed a pity that the youth of the land should have to suffer in such a real and agonizing fashion for the blindness of their elders, but it is indeed very difficult for a sincere person to find out or to know the right answers."

#### THE BASIC PROBLEM

This case, reported in barest outline, is typical of many thousands of students in our colleges although perhaps more severe than some insofar as this student had to be hospitalized. The tragedy is great no matter where or when such a situation occurs. It is prevalent among people who are intelligent, well-educated by formal standards, religious in intent and belief, and among those persons who occupy positions of great responsibility and influence. Indeed, the number of persons influential in the professions, in business and in government who exhibit regrettable emotional immaturity and lack of even elementary knowledge of the needs of young developing personalities is very great.

The point at issue is whether or not it is possible to develop the necessary knowledge and insight in large numbers of our people in order that the antecedent causes of severe and incapacitating emotional illness

and social conflict be diminished at their point of origin. Knowledge alone is not enough. Acquiring insight into the nature of one's own reactions and relationships with others is a very complicated process. Individual psychotherapy may be helpful for the few but it is too expensive for the many.

Would it not be an interesting experiment if at least a few of our influential institutions of higher learning made a serious effort to find out whether new educational procedures could be devised, or present ones modified, to permit larger numbers of our students to acquire true maturity in more areas, not simply intellectual power?

## EXPERIENCES OF COLLEGE PSYCHIATRISTS

Another aspect of the scope and urgency of this problem is revealed by an analysis of the experiences of college psychiatrists during the last four decades.

The earliest practical demonstration of the need and desire of college students for some kind of professional attention directed toward personal problems was that of Dr. Stewart Paton at Princeton in the few years following 1910. He indicated that he was available for consultation regarding matters of a personal nature, and the Princeton students "flocked to him by the dozen."<sup>1</sup> In the next few years Blanton at Wisconsin,<sup>2</sup> Menninger at Washburn,<sup>3</sup> Kerns at West Point,<sup>4</sup> Ruggles at Dartmouth and Yale<sup>5</sup> and Riggs and Terhune<sup>6</sup> at Vassar discovered that students, because of their emotional turmoil, showed great interest in mental health.

In the intervening years progress in the development of college mental health programs has been steady but slow. The largest departments are located at the Universities of California, Wisconsin and

Minnesota, Yale, Harvard and M.I.T. At least one full-time psychiatrist is on the staff of the student health services at Vassar College, Cornell, Columbia and Pennsylvania State Universities, and at the Universities of Nebraska, Massachusetts, Colorado, Pennsylvania, Indiana and Chicago.

## NUMBER OF COLLEGE PSYCHIATRISTS

A reasonably accurate estimate of the number of full-time college psychiatrists is about 38 to 40. Two recent surveys indicate that slightly more than 100 colleges have a mental hygiene program with at least the services of a part-time psychiatrist. In many of these colleges the service can care for acute emergencies only.

## FINANCIAL SUPPORT

Two institutions, Yale and Vassar, have endowments for the maintenance of a mental health program, each with \$2,000,000. The same donor provided both. Yale has elected to develop a combined program of training, treatment and research. Vassar has emphasized research particularly, and a recent report gives a good idea of its range and scope.<sup>7</sup> The other colleges and

<sup>1</sup> W. Richmond, "Mental Hygiene in the College," *Journal of the American Medical Association*, 93 (December 21, 1929), 1936-39.

<sup>2</sup> *Who's Who in America*. Chicago, A. N. Marquis, 27(1952-53), 226.

<sup>3</sup> *Washburn College Catalogue*, 1920-1921. Topeka, Washburn College, 1920.

<sup>4</sup> H. N. Kerns, "Cadet Problems," *Mental Hygiene*, 7(October 1923), 688-96.

<sup>5</sup> A. H. Ruggles, "College Mental Hygiene Problems," *Mental Hygiene*, 9(April 1925), 261-72.

<sup>6</sup> A. F. Riggs and W. B. Terhune, "Mental Health of College Women," *Mental Hygiene*, 12(July 1928), 559-68.

<sup>7</sup> Nevitt Sanford, "Personality Development During the College Years," *Journal of Social Issues*, 12(4, 1956), 1-70.



universities are usually dependent on a small portion of health fees paid by students. Very few colleges consider that mental health has anything to do with education if one judges by the prevalent lack of support.

## GOALS OF COLLEGE PSYCHIATRISTS

For nearly ten years a group of psychiatrists working with college students has been meeting regularly twice each year as one of the regular committees of the Group for the Advancement of Psychiatry. The original name of the committee was the Committee on Academic Education, later changed to the Committee on the College Student. Although the membership changes gradually, the theme continues constant—namely, what procedures, devices, methods or techniques will be helpful in promoting better teaching and learning in our colleges and at the same time contribute to greater emotional maturity of both students and faculty. Two reports have been issued, *The Role of Psychiatrists in Colleges and Universities*, in 1950 and *Considerations on Personality Development in College Students*, in 1955. In both of these reports there is an obvious effort by the compilers to go beyond the treatment of disturbed students and to utilize the ideas and principles derived from the study of students under stress in the development of more effective teaching methods and in the improvement of relationships between students and faculty. Thus it is hoped that the psychiatrist can be of service to all students, not just those with acute emotional disturbances.

## EXTENT OF STUDENT NEED

Practically all psychiatrists who have had extensive experience in working with college students agree that a very considerable

number of students in any college are likely to need help each year because of emotional problems which interfere seriously with their work. A common estimate of the number is 10% of all students. Very few institutions have psychiatric services extensive enough to see this number of students. In fact, the upper limit of psychiatric consultations and therapeutic interviews in colleges and universities at the present time is determined, not by need, but by number of hours of psychiatric time available. Thus the lack of financial and professional resources have so far prevented any definitive demonstration of the full extent of emotional illness in any student body. An unofficial survey by one psychiatrist of the amount of private psychiatric care given to students in an eastern professional school revealed that an average of five hours of psychotherapy for each student enrolled had been given the previous year (1954-55). This is far in excess of the amount of help given students by any regularly organized college psychiatric service. It does lend support to the opinion held by many college psychiatrists, particularly those who work in universities with several graduate schools, that numerous students in many of our professional schools have serious and unresolved emotional problems that greatly impede their professional development.

Psychiatrists who work in colleges are constantly under pressure to treat intensively those students who are faced with some conflict which is sufficiently severe to interfere with effective academic performance. But to yield to such pressure may mean to lose the opportunity of bringing principles derived from psychiatry to bear on the development of those students who are not apparently in trouble but who are at the same time not using their abilities

to the optimum extent. As a compromise, most psychiatrists attempt to aid in the resolution of crises, engage in brief psychotherapy for those whose outlook for mental health appears to be hopeful, and refer patients in need of definitive treatment to outside facilities. In many instances this means no help can be obtained because of insufficient clinical or financial resources.

It is important for the psychiatrist to explain to his academic colleague the nature of stress and the variety of reactions to it—both healthy and unhealthy—that students exhibit. Such knowledge should help the teacher. Formulas and rules do not work. The more the general principles are reduced to rigid rules, the less likely they are to be useful. The real secret of success is the presence of well-trained persons of keen intellect who are aware of the complex issues that are involved, and who will work with student leaders and with members of the faculty and administration as they deal with problems of students and others. This is one of the chief arguments for the establishment of training centers for young psychiatrists who are attracted to careers in college psychiatry.

### OBTAINING QUALIFIED PERSONNEL

Such a plan comes in for discouragement from various sources. Some college officials believe the presence of a psychiatrist will attract unstable students. College administrators are frequently not aware of the factors involved in attracting and keeping good young men and women in this field. Often the financial resources are not available. President Blanding of Vassar has said that support for mental health activities in a college is no more difficult to get

than other college activity providing the governing boards consider them desirable.

No college can hope to retain a competent psychiatrist on its staff unless it is willing to pay him a salary to compete with what he might make in private practice. This need not be excessive in view of many secondary benefits to be derived from membership on a college faculty, but it should reflect the long period of training that he must have had. In practice this means that the administration should know that the duties of a college psychiatrist are frequently much more taxing than those of his academic colleagues. He is responsible for life-and-death decisions. His hours are irregular. Emergencies occur frequently and often require full-time concentration for considerable periods. He is frequently the recipient of much hostility in connection with his duties, sometimes to the point of physical violence.

Many educational institutions, particularly those supported by the states, do not permit a psychiatrist on their staff to see private patients. The reasons for such a restrictive policy may be sound and logical, but in practice the result is that many positions are not filled. In the long run the personnel problem can be solved only by a composite program designed to attract good young men and women into the field by encouraging colleges and universities to support them properly and by establishing training centers. In the training programs, emphasis should be placed on devising procedures by which psychiatrists and other professional workers function as much as possible through members of the faculty and the administration rather than by treating more and more students individually as patients.

## Development of a comprehensive psychiatric community service around the mental hospital

In Britain today the isolation of the mental hospital is rapidly disappearing; this was practically absolute before the Mental Treatment Act of 1930 when, for the first time, patients were able to enter hospital as voluntary patients. The emphasis is being placed more and more on the provision of an over-all psychiatric service for the community. This enables the early treatment of psychiatric problems, the assessment of the problem relative to the family unit (with the treatment of the family unit if this becomes necessary) and the management of psychiatric problems within the community. The function of the mental

hospital would then be mainly as a centre for the treatment of difficult psychiatric problems not manageable within the community for social or other reasons.

The first trend towards management of psychiatric problems in the community started with the development of out-patient centres, and has proceeded further with the opening of day hospitals and night centres. At the same time training in the early recognition of mental health problems is being extended to general practitioners and public health officers who, in conjunction with psychiatric social workers, can then meet the needs of the demands more effectively. The emphasis is now toward the supplying of an over-all service for the community which would entail the education of the community toward recognition and tolerance of mental illness, and the early referral of psychiatric problems through the proper training of general practitioners and health visitors.

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Dr. Mandelbrote is physician superintendent and consultant psychiatrist at Coney Hill and Horton Road Hospitals, Gloucester, England. His paper, "An Experiment in the Rapid Conversion of a Closed Mental Hospital into an Open-Door Hospital," which appeared in the January 1958 number of MENTAL HYGIENE, has attracted wide attention in the U. S.



The use of a domiciliary visiting scheme provides an opportunity for the psychiatric team to assess the extent of the problem and the type of management which would enable the quickest return to normal functioning. In Amsterdam a scheme for domiciliary visiting and community care has been run by the authorities for 25 years and has proved efficacious. Dr. Querido estimated that approximately 3,000 psychiatric patients are maintained and followed up within the community. However, the Amsterdam scheme, whilst highly admirable, does not provide for a truly comprehensive service because it leaves out the mental hospital.

In Britain in some of the provincial areas, especially Nottingham and Gloucester, the community psychiatric service is provided by the psychiatrists from the hospital, with the mental hospital as the centre pivot in the service. The whole question of prevention of institutionalisation and early rehabilitation can then be combined with the over-all programme of treating psychiatric problems within the community. Admission to a mental hospital would be for specific treatment or for special social reasons where treatment cannot be carried out readily in the home, or in day centres or out-patient clinics.

In these areas as a result of the education of the general public and the co-operation of the local authorities, it has been possible to train mental health workers in such a way that they are able to participate in the follow-up and rehabilitation of psychiatric problems, in close liaison with the management of these patients by the psychiatrists from the mental hospital. This scheme also provides facilities for the follow-up of all discharges from the hospital and the review of these discharges at intervals. Many problems are managed in the out-patient clinics and day centre. Decisions relating to the

admission of problems to the hospital are made following consultation either in the out-patient clinic or following domiciliary visiting by the psychiatrist or the psychiatric social worker or mental health officer.

For the mental hospital to play its role effectively it is very important to remove the barriers isolating the hospital from the community and to provide an internal psychotherapeutic atmosphere within the hospital, which in turn will have the function of further enlightening an informed public opinion in the community. To obtain this sort of atmosphere is not possible within the framework of custodial care and a locked door system. Another major barrier is certification. Many critics of these alterations in mental hospital management maintain that these procedures cannot be avoided without embarrassing the hospital and presenting a hazard to the community and difficulties in getting patients to come for treatment.

This has not been my experience; within the last three years it has been possible over a period of six months to facilitate the opening of the doors of the hospital<sup>1</sup> and a 30 months follow-up shows that the difficulties encountered have been extraordinarily few, although not completely without mishap (see Table 1).

An interesting experiment was carried out over a 12-month period in which certification was avoided by the use of temporary admission under a section order (a short-term order extending from 3 to 28 days) usually carried out by the mental welfare officer on the advice of a psychiatrist without the presence of a magistrate. This order is described as an observation order and

<sup>1</sup> B. M. Mandelbrote, "An Experiment in the Rapid Conversion of a Closed Mental Hospital into an Open-door Hospital," *Mental Hygiene*, 42 (January 1958), 3.

TABLE 1

*Difficulties encountered in an unlocked hospital*

	6 MONTHS PRIOR TO OPENING DOORS	6 MONTHS AFTER OPENING DOORS	12 MONTHS AFTER OPENING DOORS	18 MONTHS AFTER OPENING DOORS	24 MONTHS AFTER OPENING DOORS	30 MONTHS AFTER OPENING DOORS
Absconders *	28	29	57	33	48	24
Destructive and impulsive patients	(Av.) 123	30	30	23	5	4
Seclusion	256	40	10	16	3	-
Bed patients	(Av.) 100	20	20	20	19	8
Incontinent patients	120	45	31	28	22	16
Fractures	13	8	6	10	9	16

\* Frequent absconders were retained in closed groups. These closed groups included 5 male patients (2 chronic wanderers and 3 difficult young schizophrenics) and 5 female patients, all chronic wanderers.

The casualties included 1 deteriorated schizophrenic who wandered off, was lost and was later found dead, 1 woman victim of obsessional depression who committed suicide by throwing herself into the river (she had been treated with 9 ECT's) and 2 patients who absconded and whose whereabouts are not known.

TABLE 2

*Outcome of 200 patients under observation  
July 1956 to June 1957*

JULY 1957		31ST DECEMBER 1957		REVIEW 31ST JULY 1958	
Becoming voluntary	160	Discharged	123	Out of hospital	134
		Deaths	8		
		Re-admitted	5		
		Continued in hospital	24	In hospital	33
		Out of hospital	13	Voluntary	29
Discharges on expiration of order	23	Re-admitted	10	Certified	4
		Becoming voluntary	7		
		Deaths	1	Transfer to other hospitals	1
		Discharges	2		
Deaths	17	Including 1 transfer to an other hospital			
				Deaths	32

Of the 9 discharges on expiration of order not re-admitted, 2 are in welfare homes and 7 in the community (5 of whom are known to be improved).

is for the patient frequently not very different from the ordinary type of admission that the individual encounters going into a general hospital.

As a result of diligent application of this section it was found that out of 760 patients admitted during the year from June 1956 to June 1957 it was necessary to admit 200 patients under an order of this nature in order to prevent compulsory detention (see Table 2).

The outcome of these patients is very interesting; in the vast majority of cases, as a result of early treatment and classification and the atmosphere within the hospital, 84% of them remained as voluntary patients and completed their treatment with satisfactory result. In only 14 instances were second admissions on an observation order necessary over the next 12 months and in only 4 instances were these orders repeated. Following up these patients a year later shows that only 4 of these patients required eventually to be certified, and in each of these 4 cases attitudes have changed in such a way, as a result of relationships made with doctors and others, that the patients would be willing to continue to co-operate and they will probably be regraded as voluntary patients.

The extent to which patients can co-operate within a homogeneous and thera-

peutic atmosphere within the hospital is also an interesting question. In this particular hospital three years previously out of a total of 1,529 patients 1,045 were certified patients. By the simple process of regrading patients who seemed suitable as voluntary patients—namely, those who would not leave the hospital against advice—it has been possible to reduce this number to a mere 19 over a 3-year period and I have little doubt the number could be further reduced until there were virtually no certified patients at all (see Table 3).

Achievement of co-operation and willingness for treatment depends to a large extent on the atmosphere and morale within the hospital. Interpersonal relationships which take place inside the hospital play an important part, together with encouragement of patient participation in responsibility, thus enabling them to find a place for the use of their assets and talents.

In addition to the essential preliminary methods of opening doors and removing certification, the problem of overcrowding has to be dealt with so that the patient can receive adequate individual treatment. This problem can be tackled only within the framework of community treatment which facilitates the use of the mental hospital for active treatment, and the early rehabilita-

TABLE 3  
*Patients remaining on the hospital register*

	1958	1957	1956	1955	1954
Voluntary	1,173	1,082	684	473	479
Temporary	—	—	2	4	5
Certified	19	210	681	944	1,045
Total	1,192*	1,292	1,367	1,421	1,529

\* 1,134 (May 1959).



tion of problems that can be managed within the community with psychiatric supervision. It is facilitated by stringent attempts to prevent institutionalisation, which is rampant throughout the mental hospital, and by encouraging patients' participation in responsibility and management in contrast to the dependent attitudes produced in the past. Facilities for adequate occupational therapy, social and recreational functions, and rehabilitation designed toward fitting the patient for the community are necessary. Temporary return to the community is encouraged through maintaining contact with relatives. Frequent visiting, weekends at home and longer periods of leave are arranged as the patient improves, and in some instances gradual weaning is achieved through the use of a day unit or attendance at a day or night hostel.

Community tolerance of minor forms of aberrant behaviour or handicapped functioning is required, and is very much dependent on community education and the relationships that the community have with the mental hospital. Until the patients begin to speak highly of their management and treatment within the hospital, one cannot expect the public to look with enthusiasm and favour on psychiatric treatment and management within the mental hospital.

In order to alter public attitudes favourably towards early treatment, decoration and modern amenities are necessary in at least a few of the wards, with the eventual aim that the mental hospital should provide sufficient of an aesthetic atmosphere to prevent the patients or their relatives developing the feeling of being put in surroundings where nobody really cares.

Once the viewpoints of the patient, the atmosphere of the hospitals and the attitude of the community have tended toward ad-

justment then each reacts beneficially on the other. In Gloucester, following the formation of a League of Friends and the encouragement of visitors into the hospital, members of the public have begun to participate in hospital functions to the extent of providing leaders for gardening clubs, camera clubs, art classes, domestic science classes, French classes and singing classes; the Women's Institutes have become a focus for re-introduction of small groups of long-stay patients into the community. This has been followed by the purchase of a hospital bus which enables 15 patients to enjoy a daily outing to local Women's Institutes or British Legion Clubs, and the entertainment has become mutual in that the Women's Institutes have repeatedly invited the same groups of patients who visited them before. The entertainment consists of entertainment to tea, organisation of games such as musical chairs or darts and skittles for the men, and in some instances have had considerable educational value in that patients have been invited to interesting homes and learnt something about furnishings and gardens and the local history of the community centre that they are visiting. This contact begins to extend further as the prestige of the hospital treatment increases and can provide an effective liaison with employment exchanges, local employers and other agencies in the community whose help the patients are likely to need.

The extent to which home visits play a part can be indicated by the following figures (see Tables 4 and 5).

Throughout 1957, 288 patients were visited in their homes by a psychiatrist and a considerably larger number by mental health workers and psychiatric social workers. Of these 288 approximately 50% required to be admitted to hospital. One year's follow-up showed that in only five

TABLE 4

*Domiciliary visits, 30th June 1956 to 1st July 1957*

NUMBER OF VISITS	MANAGED OUTSIDE OF HOSPITAL	ADMISSIONS TO HOSPITAL		OUTCOME OF PATIENTS ADMITTED TO HOSPITAL		
		Voluntary	Section		Discharges	Deaths
			20	21		Still in Hospital
288	132	125	11	20	144	7
						5

instances were patients still in hospital, emphasising the extent to which close contact with relations and early recognition of the patient's illness can facilitate improvement and simplify the over-all management and care of the patient.

A very large number of chronic problems that are sifted to the mental hospital, especially in Britain, fall into the category of social or geriatric problems. These are in addition to the hard core of chronic psychiatric problems in the mental hospital, to some extent perpetuated by long periods of custodial care. Without proper screening and a community service for classification and management of geriatric problems within the community, rapid overcrowding of mental hospitals would very readily once again occur—thus defeating attempts to provide a therapeutic atmosphere within the hospitals, which is so vital to the morale of the patient and which so much affects the judgement of the mental hospital by the community as a whole.

Quite apart from the correct classification and screening of geriatric and social problems there are two major categories of chronic psychiatric problems which can be managed far more adequately in the community with psychiatric supervision than is supposed. These two categories include chronic schizophrenia, especially chronic paranoid states allied to schizophrenia, and

psychosis in the senium, especially senile paranoid psychosis and mild forms of senile dementia.

It has been found possible to manage a number of these schizophrenic states comparatively well with adequate psychiatric supervision, especially now that tranquillising drugs deal so effectively with disturbed

TABLE 5

*288 cases seen on domiciliary visits*

CATEGORIES	TOTAL
Psychosis	128
Schizophrenia	38
Paranoid states	27
Manic states	6
Endogenous depression	53
Epilepsy	2
Alcohol	1
Mental defective	1
Dementia	46
Senile	38
Organic states	8
Psychoneurosis	90
Anxiety states	24
Anxiety with depression	42
Anxiety hysteria	5
Hysteria	18
Obsessional neurosis	1
Severe Personality Disorders	24

The setting in which the patient has treatment is usually regarded as being subsidiary to the actual treatment itself. However, it is becoming apparent that the setting for treatment is also of therapeutic value, for unless it is possible for the patient to be treated without marked loss of self-respect and unless the doctor/patient relationship can be adequately preserved, difficulties arise which may adversely affect the extent to which the patient improves.

For example, a woman in her middle forties who was floridly disturbed with paranoid delusional ideas was recently referred. On a previous occasion she had been forcibly detained and certified, spending 15 months in a mental hospital before discharge. Initially she refused to be seen—associating the referral with the previous procedure that led to her certification. She agreed, however, that if an independent non-medical witness said she ought to come into a mental hospital she would come. Arrangements were made for admission under a short-term order for observation, and treatment was started. The patient, shortly after admission, attended the day centre and made good contact with the staff there. After four weeks of treatment with Largactil and contact with the therapeutic procedures present in the day centre, she was fit enough for discharge, having spent the previous two weekends at home with her husband. She went away on a holiday and was seen subsequently in the out-patient clinic, which she attended willingly. She had stopped taking her Largactil tablets and had made a good improvement and expressed her willingness to continue contact with the clinic, saying that now she had got to know us and knew she was not going to be removed by force, she was perfectly willing to come to us for assistance.

Deprivation of civil rights and restriction

undermine self-confidence and aggravate emotional disturbances, destroying the vital personal relationships, mutual confidence and trust which I think has an important bearing on the management of patients, especially psychotics. Even the chronic psychotics who do not necessarily lose their delusional convictions can be managed and rehabilitated more readily when this personal relationship exists.

An important aspect of any such problem is the extent to which the family and community relationships have been disturbed as a result of the patient's behaviour and the treatment of the patient. The outcome of the treatment will be very closely bound up with the attitudes of the family and the community. Once the family or the community close their ranks to the patient, attempts to restore the patient in their midst are strongly resisted and minor behaviour disturbances are not tolerated readily. By maintaining good contact with the family and helping the patient and family with their differences and difficulties, institutionalisation problems are lessened and rehabilitation is made easier. This is facilitated by schemes of domiciliary visiting, keeping the family informed about the patient's problems and advising how difficulties can be managed. In this way families are encouraged to take patients out for short periods, weekends and longer periods at home when they begin to improve.

The mental hospital segregates patients into artificial groups and is really only suitable for short-term treatment and rehabilitation, but not for long-term treatment and social readjustment. Social readjustment is really in the sphere of the family and the community. If the family is not disrupted it is used to dealing with problems of this nature. When family attitudes can be canalised into therapeutic channels the family unit serves a very useful purpose in



assisting towards easier social adjustment, uncomplicated by awkward and aggressive attitudes which are built up more readily in a setting of compulsion and restriction. In the chronic psychotic, symptoms, although not eradicated, cease to be a major or dominating feature in the patient's existence in many instances—evidenced by the large number of chronic psychotic patients living in the family unit (half-way annexe accommodation) who have been discharged back into the community (see Table 6). The more flexible management of community treatment encourages the patient's natural tendency to social readjustment and helps him to remain in the community despite the handicap of chronic psychosis.

Development of a scheme of this nature also results in closer contact between the general practitioners and the psychiatrist, and interested general practitioners are being helped in the management of their patients as a whole. This close contact through domiciliary visiting is being extended with the holding of seminars in mental health clinics for general practitioners, thus encouraging them to refer patients early, and assisting them in the appreciation, understanding and even management of psychiatric problems. It not only makes possible the continuity of care for all forms of psy-

chiatric illness, but it helps the patient and the public to accept the mental hospital and the mental health department in the sort of way that they accept the general hospital and other public health services.

#### SUMMARY

This paper deals with the development of a comprehensive psychiatric community service based on the mental hospital. It involves the setting up of out-patient clinics, day and night centres and a domiciliary service, the education of the community towards recognition and tolerance of mental illness and the training of family doctors and public health officers—in this way facilitating early referral of psychiatric problems and the continuity of management of these problems.

The mental hospital is seen primarily as a therapeutic community for the treatment of difficult psychiatric problems not manageable within the community for social or other reasons. The emphasis is laid on the extent to which many chronic psychiatric and geriatric patients could be managed within the community, with better facilities for continuity of care if the isolation of the patient from the community is prevented and the community learns to tolerate some eccentricities of behaviour.

## Sample survey of admission of ex-mental patients in rehabilitation centers

In an effort to ascertain the extent to which leading rehabilitation centers are including ex-mental patients in their programs, an inquiry was sent to 86 such centers throughout the country in the fall of 1958. A total of 78 replies were received. The replies came from 28 states, representing 58 local communities in the United States and Canada. They indicated that 23 centers were currently serving ex-mental patients; 40 centers did not include such patients in their programs, and 15 centers were planning to have such patients included in the near future. Thus, out of 78 centers, 38, or almost half, either had programs or were planning programs for the ex-mental patient.

Of greater significance than the statistics is the actual range of programs supplied by those centers which were serving the ex-mental patients. The following excerpts, culled from correspondence and reports re-

ceived from these centers, demonstrate graphically their successful experiences in serving the ex-mental patient.

### REHABILITATION CENTERS WHICH ADMIT EX-MENTAL PATIENTS

#### ARIZONA

Samuel Gompers Memorial Rehabilitation Center of the Maricopa County Society for Crippled Children and Adults, Inc., Phoenix: "At the present time we are making our services available to a limited number of ex-mental patients who are referred to us by the State Division of Vocational Rehabilitation. These referrals are for our pre-vocational evaluation unit. We utilize the "Tower" system of pre-vocational evaluation and from all indication the neuropsychiatric individual fits quite well into this program. . . ."

#### CALIFORNIA

Herrick Memorial Hospital, Berkeley: "Our center at the present time is a small

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Mr. Klapper is assistant executive director of the National Association for Mental Health.

one (16 staff members) with a caseload of a little over 1,000 patients per year. It is operated as a community project in a general hospital. We have no restrictions as to diagnosis, age, etc. The only criterion is self-care though it may only be a limited one. Primarily our mental patients have had actual physical problems either caused by suicidal attempts or disease or injury sustained prior to the mental illness. It should be pointed out that most of our mental patient referrals come from our hospital's 46-bed psychiatric unit. The pa-

### *Rehabilitation centers contacted*

	NUMBER
Inquiries	86
Replies received	78
Have program	23
No program	40
Anticipate program	15

tients are housed there and are admitted primarily for their psychiatric problem. Due to our active and large psychiatric service, seldom is a patient whose major problem is mental referred to the center without being under psychiatric care. Most of the referrals are for physical medicine services.

"Occasionally, we also receive outpatient referrals from the local state mental hygiene clinic and our own part-pay clinic.

"In regard to statistics, I have none. My guess would be our mental patient caseload does not exceed 2%. We have always considered psychiatric patients as we would any others with additional supervision only when notified by the psychiatric department of any special precautions. Actually we have never considered them a problem. The physical disability patients seem to accept them tacitly. The socialization and group dynamics in the treatment areas have

not been noticeably affected. It should be remembered that most of our mental patients are still quite acute and are often on treatment. More disturbing to the group are physical disability patients who are having difficulty with acceptance and are not having any help with their emotional problems.

"As noted in our brochure we are going to have 50 in-patient beds. Our administration feels that ultimately the psychiatric unit and ours will be coordinated. This will prevent unnecessary duplication of many services which are common to both. Our hospital has become so oriented to the idea of complete rehabilitation that our administration sees no need for separation of services to patients on the basis of diagnosis. I believe that psychiatric patients can benefit particularly from the vocational services of a center . . ."

### CONNECTICUT

Rehabilitation Center for the Physically Handicapped, Inc., Stamford: "Originally, we just took workers with orthopedic handicaps. Later, in order to more adequately serve the needs of the community, we have taken workers with other disabilities including the epileptics, arrested T.B.'s, cardiacs, etc.

"Through the years we have had a limited number of emotionally disturbed workers in the sheltered shop. These workers have been under medical care and usually under medication. In our past experience we have found this group to be the most difficult and unpredictable of all the disabilities we work with. Periodically, for instance, one of them 'hears voices' and is talking with imaginary people. This can be very confusing and disrupting to the production of the other workers sitting near him. We have often felt that we would like to know more about how to



work with them—we feel the need of much more background in dealing with them.

"Our pre-vocational evaluation department and the sheltered shop are the two services used by this group in the past. Our pre-vocational evaluation department helps them determine a logical vocational goal, and the sheltered shop offers a work training opportunity as well as an opportunity for developing social relationships and work tolerance. We work very closely with the Connecticut State Bureau of Vocational Rehabilitation in those cases eligible for this service.

"Our medical board has been considering the problem of the disturbed and are aware of the situation that more and more ex-mental patients are being returned to the community and need help in 'bridging the gap.' The subject has been discussed at several of their meetings this past year. It is their feeling that the number of emotionally disturbed patients in pre-vocational evaluation and sheltered shop should be increased gradually. But they feel there perhaps should be some control as to the type and severity of the case. They are planning to add a psychiatrist to the medical board (a policy-forming group) to help them develop medical policy as it would relate to this group . . ."

#### IOWA

Department of Public Instruction, Division of Vocational Rehabilitation, Des Moines: ". . . we have served a number of ex-mental patients as well as mentally retarded persons. Our services to this group have consisted of personal adjustment training, vocational exploration and evaluation and on occasion some training . . ."

#### INDIANA

Crossroads Rehabilitation Center, Indianapolis: "Our work with mental patients has

been quite limited. We do take a few from Central State Hospital, which is a state institution for the mentally ill, and from La-Rue Carter, which was set up as a screening institution for mental patients.

"As I said, we have a limited number of cases, taking approximately two per month. These patients remain under the care of the institution and spend their nights there, and days, of course, are spent at our center. To date we have had about 14 patients—two of them were, in our judgment, a complete failure. The other 12 have been completely rehabilitated; two of them are on our staff at the present time . . ."

#### MINNESOTA

University of Minnesota Medical School, Minneapolis: ". . . At the present time the rehabilitation center provides vocational services for psychiatric inpatients of the University of Minnesota hospitals. When the Department of Psychiatry believes vocational services are indicated for one of their patients, consultation with the Department of Physical Medicine and Rehabilitation is requested. An evaluation of the patient's resources in meeting the demands of the current labor market—which involves the use of intelligence, aptitude, proficiency and interest tests—is carried out as a beginning step. In addition to these methods, the prevocational unit of the rehabilitation center may be used to provide additional information, particularly that concerned with the patient's ability to adjust to competitive work situations. With the information provided by the Department of Psychiatry staff, the prevocational unit and testing procedures of the center, the vocational counseling section of the rehabilitation center can set up various programs or goals. For example, job placement services are available for those patients not directly employable, or sheltered workshop place-

ment for those patients who need a 'half-way house' type of program. The range of vocational services is continued to the point where the patient has either been successfully placed on a job or until it is felt that no further benefit can be obtained from the vocational services of the center . . ."

Duluth Rehabilitation Center, Inc.: "Our current rehabilitation program is set up to handle only patients who are in some way physically disabled. However, we do, when requested by a local doctor, accept occasional ex-mental patients for therapy in our occupational therapy department. Our reason for restricting the caseload has been, chiefly, that we do not have sufficient floor space or personnel to assume an additional number of patients. Also, we are a young center and were set up primarily to deal with physical disabilities.

"Like most growing centers, we do realize the need for help for the mental patient who has been released from direct care. We feel that if we are to be a true community rehabilitation center, we will someday have to assume the responsibility for offering services to these people. At the current time, our board of directors is considering the possibility of adding pre-vocational exploration services to our program. If this service is added, we will definitely make plans to include the mental patient. Work adjustment training will be of special importance. We feel, too, that as we are able to expand our occupational therapy department, we will be able to offer more, in that area, to the mental patient.

"You have undoubtedly heard of the Minnesota follow-up study which is currently being instigated here in Duluth. There is a very good possibility that our center will be utilized to help in assisting patients from this project back into everyday living. We will welcome the oppor-

tunity, especially if we are able, at the time, to expand our facilities and personnel . . ."

#### MISSOURI

Rehabilitation Institute, Kansas City: "We have worked closely with the Psychiatric Receiving Center located in Kansas City, and with the state hospitals, particularly those in St. Joseph and Nevada, in programs for their patients. Also, we have a good many referrals from psychiatrists in private practice. We have been working with the local Mental Health Association in providing services.

"Sometimes it is a program in occupational therapy including socialization for better adjustment to home. Others are accepted in our work evaluation and work adjustment unit for preparation for return to work or training. This program is carried on in cooperation with vocational rehabilitation.

"We have been doing some experimental work with patients who remain as inpatients at the Psychiatric Receiving Center but are brought to us daily for a program in work adjustment outside the hospital. If they adjust well, arrangements are made for their release and job training or placement is pursued. All resources of the institute for other services, as indicated, are available to these patients . . ."

Jewish Hospital of Saint Louis: ". . . As to our plans for the future we will be activating both adult and child psychiatric units later this summer and both these units initially will use selective services from the Rehabilitation Division. I am sure that as the program develops a more definitive program will be set up . . ."

Rehabilitation Center of Greater St. Louis: "Our program is with the neuropsychiatric patients who are receiving treatment and

under the care of a psychiatrist. They are outpatients except for a few who are inpatients of our state hospital and come to us for a period of adjustment before discharge."

#### NEW YORK

Rehabilitation Services, Inc., Binghamton: "In our sheltered workshop program we have various disabilities admitted on a percentage basis. This runs perhaps 5% or 10% either way; however, generally speaking only about 2% of the admissions to the workshop are of a psychiatric nature. Out of the present enrollment of 235 sheltered workshop workers there are 7 people that are in this category. This includes mental retardation, nervousness and mental treatment patients. To my knowledge the sheltered workshop does not plan any further expansion of this program . . ."

Tri-Lake Rural Rehabilitation Services, Saranac Lake: "In general, the Guild has been gratified by the progress of these cases although there has of course been a percentage of failure. The Guild has felt a particular obligation to service ex-mental patients since training facilities where adequate supervision was available are few and far between . . ."

Mobility Rehabilitation Services, Treatment Center and Workshop for the Physically Handicapped, New Rochelle: "Mobility has been involved in the after-care of mental patients for several years. We have not labeled it as such for various reasons and we have been quite selective, but the service has been definite and—we feel—productive.

"In our workshop we have accepted trainees with other than orthopedic disabilities. In fact, most of our trainees are cardiacs, inactive TB's, mentally retarded,

accident cases who didn't respond readily to standard medical treatment, epileptics, etc. Due to pressure from after-care personnel, we have evaluated several ex-psychotics and placed them in our shop. We have felt that their progress was at least average. The benefits of working in a sheltered, understanding environment, as work tolerance is developed, are undoubtedly known to you. We are in an excellent position to provide liaison with those other community resources required by the trainee in his rehabilitation process. Our focus is on integration of the trainee into a normal, competitive environment outside of our shop.

"The limitations of such a service are as obvious as the benefits. Trainees with a mental illness history require varying amounts of close, readily available case-work. This usually does not include by definition monthly visits to after-care clinics.

"For example, if we were to expand our workshop services for the mentally ill, we would require a full-time psychiatric social worker (or counseling psychologist) who would be available at all times. Psychiatric consultation and psychological services would be required to help plan and supervise the individual programs. We feel that the mental illness trainees who have left the shop against advice might have remained and been helped, if their day-to-day problems could have been met as they arose. This was not possible through our present social services, due to the pressure of other duties and the difference in focus of the job classification. In my opinion it is not realistic to expect the necessary psychiatric supervision for workshop trainees to be provided exclusively outside the workshop setting. Ideally, there should be close coordination of supervision within the setting and without.



"From an administrative standpoint, the greatest problem is provision of the physical plant and production personnel necessary, if a work setting is to be provided. Mobility already has this and is building up its supply of subcontracts which provide work for the trainees. Despite an efficient management, subsidy averaging about \$13,000 a year has been required to keep an average of 25 trainees working. The professional personnel needed to expand services for the mentally ill would necessitate additional subsidy. If the number of such trainees grew, a specially oriented floor supervisor would be needed for instruction and job supervision . . ."

Rochester Rehabilitation Center, Inc.: "During the past four years we have had convalescent psychiatric patients referred to the Center for Occupational Therapy and Work Evaluation in our industrial division and on two occasions for physical therapy. These statistics are as follows: 1954-55, 7 occupational therapy; 4 industrial division; 1955-56, 3 occupational therapy, 3 industrial division; 1956-57, 2 physical therapy, 4 occupational therapy, 4 industrial division; 1957-58, 2 occupational therapy, 3 industrial division. We have not been very successful having the psychiatric patients placed in competitive industry; however, we have found that they can adjust to a sheltered environment, such as exists in our industrial division. The main emphasis in the occupational therapy division for this group of patients has been one of helping them develop stability to meet new situations and to consider a vocational goal. We have also found that no matter in which division the patient is enrolled, it is definitely a long-term process . . ."

Institute for the Crippled and Disabled, New York City: "... we have limited our services in the past to those who have a

physical disability. A substantial portion have had extensive emotional problems not unlike those of the mental patients. To deal with these problems we have incorporated in our services a licensed mental hygiene clinic staffed to deal adequately with such problems.

"Because of this psychiatric effort, we have been encouraged to consider the acceptance of mental patients being discharged from the mental hospitals or other mental health facilities. We are approaching this on a cautious experimental basis. A limited pilot program has been under way for the period of a year through the acceptance of referrals from the Brooklyn Day Hospital. We are now negotiating with DVR to accept a limited number of carefully prepared referrals from them. It is our hope to gain experience and insight into the problems of this type of patient and to determine if they can be assimilated with our other clients. If this preliminary work develops satisfactorily, we will then be able to extend our services to this group considerably.

"One of our expanded services is our workshop, which has moved into 18,000 square feet of rented space. We look upon this as one of the areas in which relatively long-term transitional employment may be offered to mental patients concurrent with the necessary psychiatric care. The end objective would be to return the client to gainful employment . . ."

#### OHIO

Goodwill Industries Rehabilitation Center, Cincinnati: "... One frequent program that we have is in connection with local hospitals, whereby the mental patient continues on an in-residence service at the hospital for nights and week-ends but comes to Goodwill for training and preliminary employment services until he is ready for discharge.

Transitional employment is offered to these and to other mental patients until they are capable of employment in competitive industry.

"Other programs include testing, counseling, work evaluation and social services in addition to those listed above for patients who have been discharged, or for those who are being seen on an outpatient basis . . ."

Vocational Guidance and Rehabilitation Services, Cleveland: ". . . The Greater Cleveland area has several private and state-supported psychiatric OPD's, neuropsychiatric wards and 'mental' hospitals. We share the responsibility along with the local Ohio BVR office for accepting referrals of mental patients to develop and follow through in a rehabilitation program. The BVR office recently placed a full-time vocational rehabilitation counselor on the Cleveland State Hospital staff to help identify patients who are ready for vocational rehabilitation planning.

"A survey of 150 clients admitted to our program between January and May 6, 1958 reveals 9% of them were referred because of emotional, mental or behavior disorders. There are others who are referred because of physical or intellectual disability who have an equally disabling mental or emotional problem. I would estimate this group at 25% of our total population.

"Our experience with mental patients has been interesting and has shown that many mental patients can benefit to some degree from vocational rehabilitation. We have had somewhat more success with the discharged mental patient who does not require continued medication to maintain his post-hospital adjustment. Even on medication there is some benefit in many cases.

"At the present time many of the referrals coming from mental hospitals are patients who live in the hospital and are being fol-

lowed psychiatrically while they are active in a rehabilitation program with our agency. If employment can be secured, the patient is then released on trial visit for six months. In the meantime our vocational counselor is active with him from his initial contact through his employment and continues until he is vocationally stable . . ."

Goodwill Industries of Dayton, Inc.: "In 1957, we had 15 direct referrals from the Dayton State Mental Hospital. We may have, and in fact did, work with other clients with severe emotional problems, but 15 is the number of direct referrals from the local mental hospital. The social service department in the hospital referred those discharges to us for our specific services which are all vocationally oriented. This means then that the social service department of the hospital felt that the referrals here were ready upon discharge to consider some vocational goal. Our major function was to render one of the following vocational services—vocational evaluation, work adjustment, vocational training, sheltered employment or competitive placement. While receiving one of these services the client may have also been receiving counseling from our own staff psychologist, from our consulting psychologist or from re-visits to the outpatient department of the state hospital. In several instances, the client or patient continued living in the state hospital during the vocational evaluation process, being released only upon the establishment of a vocational objective. In nearly every case, the Bureau of Vocational Rehabilitation participated in the programming generally to the extent of sponsoring the client to service here . . ."

#### PENNSYLVANIA

Harmarville Rehabilitation Center, Pittsburgh: ". . . Heretofore, this center has been

very active in the area of physical disability. We are now in the process of expanding to include patients who are emotionally disabled. It is hoped that some patients might avoid institutionalization and other patients be helped to return to the community, jobs and families, through a day-care program, with some inpatient beds where necessary. We hope to have this program in operation this summer, and are presently awaiting word from the State Department of Welfare regarding approval of funds from programming such a day-care activity for psychiatric patients . . ."

#### VIRGINIA

Woodrow Wilson Rehabilitation Center, Fishersville: ". . . During the past year our enrollment has averaged 375 resident students. Fifteen percent of these are mentally retarded and 5% had mental and emotional disturbances. A very large majority of our students with mental problems have come to us from the state mental hospitals. Some of our outstanding successes, as well as our outstanding failures, have been in this group. We have made no special plans for these students other than attempting to do a good evaluation of the student's potential for adjustment before accepting them. Once they are accepted a counselor is assigned who works closely with the student while he is undergoing a rehabilitation program. These students have adjusted well in our business school and in our nurse's aide training. We have also trained some of them in food service in our dining hall and canteen.

"At the present time we are talking with the doctors of the mental hospitals looking toward further coordination of the two programs. The patients are furloughed from the hospital to the center and we find

that it is very helpful to be able to return the patient to the hospital if our psychologist or psychiatrist feels it is advisable . . ."

#### WEST VIRGINIA

Vocational Rehabilitation Division, State Board of Vocational Education, Charleston: Has served 41 ex-mental patients.

#### WISCONSIN

Curative Workshop of Milwaukee, Inc.: ". . . Our experience with mental patients is not too extensive; nevertheless, we have been handling both psychiatric and mentally retarded patients for many years.

"The psychiatric patients are usually referred by the patients' private physicians for occupational therapy, group socialization and sometimes physical therapy. During the past several years we have also been requested to provide vocational evaluation, counseling and placement services for patients recently discharged from various psychiatric hospitals. Our psychologist and social workers work closely with the patients' psychiatrists in developing and carrying out a suitable plan of action for these patients aiming at their maximum rehabilitation.

"Although we, at present, do not have any special formalized program of services for this separate group of patients, we have often discussed the advantages of such and believe there is a great need for an effective program of services especially geared to these patients.

"To date, the physically disabled have dominated our attention; however, I believe we are now in a position to give the mental patients more attention. I believe that a center of this type could easily gear a special program of services for the mental patients on an outpatient basis which could



effectively assist these patients in their total adjustment and rehabilitation . . ."

#### REHABILITATION CENTERS WITH NO PRESENT FACILITIES, BUT WITH FUTURE PLANS

##### COLORADO

Goodwill Industries of Denver: "Our Goodwill Rehabilitation Center has not had any experience in serving ex-mental patients but our plans include such service and we are hopeful of developing a program for these persons in the near future."

##### CONNECTICUT

Hartford Rehabilitation Center, Inc.: "We are currently investigating the possibility of providing rehabilitation services to mentally ill patients with both the local Veterans Administration and the Greater Hartford Association for Mental Health.

"We have been philosophically committed to the concept of serving the emotionally ill person since our association with the rehabilitation field. The limitations of facility, personnel, budget—and the initial attitudes of many of our own physicians—have all been obstacles to this development.

"Today, we can point with pride to a recently completed 2-year pilot study in rehabilitation services for the mentally retarded. We had the same kind of barriers to overcome here. We persisted and have demonstrated to the satisfaction of all that the comprehensive center can meet the needs of a selected population of retardates and that this group can be treated together with the physically disabled with resulting benefits to all concerned. . . .

"This gives us both the justification and increased initiative in pursuing our next major goal, that of services to the mentally ill. We are in the very exploratory phase of this undertaking, but have high hopes for the future."

##### DELAWARE

Delaware Curative Workshop, Inc., Wilmington: ". . . 1) The Delaware Curative Workshop does not provide direct services to the victims of mental illness. 2) We do have physical facilities and professional staff to offer such service in the future. 3) We would like to cooperate with related agencies in developing any programs of rehabilitation which might be indicated to better serve Delaware."

##### INDIANA

Rehabilitation Center, Evansville: "Up to this point our program has been limited to persons with physical disabilities. However, within the next two weeks we will be moving into our new facility where we will have much larger quarters and potentials for very great increase in our service program.

"It is my personal feeling that as our program and staff do expand in our new facility we should seriously consider the inclusion of services for individuals recovering from mental disability. I would think that the pre-vocational exploration unit in our new center would be particularly adaptable to the provision of services to this group. In fact, I have had some very preliminary conversations with the social service administrator of our local state hospitals about the development of such a plan at some future date. Of course, the prime consideration in the initiation of services to mental patients would be the question of availability of funds to finance a program for them.

"It is my belief that rehabilitation centers should have as their goal to develop programs of service to individuals with all types of handicaps just as rapidly as the need is demonstrated, competent personnel

are available and financial support is forthcoming."

#### KENTUCKY

Rehabilitation Center, Inc., Louisville: "Our future program plans include a broad sheltered workshop program that will enhance the training of the ex-mental patient and readjustment programs in association with the 'halfway house' that has been established here in our community. It is our hope to integrate services to the mentally retarded, cerebral palsied patient, and those with physical disabilities in this area. If we can develop such a program we hope we can interest industry in working with us in developing the modified industry area for permanent employment of those people who find it impossible to compete in regular industrial pursuits.

"Our future planning is not in the building stage as yet and we, of course, are among the many faced with the problem of acquiring funds for the development of such a program . . ."

#### MASSACHUSETTS

Boston Dispensary: "We have given considerable thought as to how the rehabilitation institute at the Boston Dispensary might be of value in a mental health program . . .

"It would seem to us that we could be of value in doing vocational evaluation and occupational therapy and pre-vocational testing in connection with post-hospital planning for mental patients. We have a good psychiatric clinic in the dispensary and a full-time clinical psychologist in the institute, in addition to the social worker and vocational counselor to assist the therapy group. There is also a possibility that our psychiatric service may be con-

siderably expanded in the fall and, if that should take place, we could certainly participate in periodic follow-up and re-evaluation of post-hospital patients."

#### MICHIGAN

Detroit League for the Handicapped, Inc.: "We are seriously considering this project in our future planning, but of course, we cannot at this time determine the extent of service we can or will be able to give in this field."

Rehabilitation Institute of Metropolitan Detroit: "To date, we have not specifically admitted any patients who have a primary diagnosis of mental illness . . .

"In the future, we do not know exactly what the development along this line will be. Certainly, we are established in Detroit to provide comprehensive services for the patients within this area. If a need develops in the sphere of mental illness and if we have services which significantly offer these people a better opportunity to return to their communities healthier and better able to adjust to their future lives, then I am sure we will endeavor to set up programs which will help them . . ."

#### NEW YORK

New York University-Bellevue Medical Center: "Unfortunately, we have not had any real experience in providing services to ex-mental patients at the institute.

"This has been under discussion, however, for some time and I am forwarding your letter to the director of Psychiatric Services Division of the institute, and I know that he will write to you directly, informing you of whatever thinking is now taking place on this matter.

"I am sure that there is a great need for this additional service in the field of re-

habilitation and I am glad to see some action in this direction."

Chronic Disease Research Institute, University of Buffalo: "We are a medically oriented physical medicine and rehabilitation center, and therefore are limited as to the types of services which can be offered to ex-mental patients or patients on convalescent care. We realize that there is a great need for rehabilitation services to such patients, and the Buffalo Council of Social Agencies is in the process of completing a survey as regards broad rehabilitation for this community. As I have been an active participant in this survey, I know that one of the strong recommendations will be for a more comprehensive rehabilitation center which will offer services of social adjustment and work adjustment and tolerance for the type of patients mentioned in your inquiry, in addition to the services now available."

#### OHIO

Rehabilitation Center of Summit County, Inc., Akron: "... the Rehabilitation Center of Summit County has not provided such services.

"The Rehabilitation Center does not have a workshop or a work evaluation area at present. We sincerely hope that such a workshop can be developed soon. Our obstacle here, of course, is funds to equip and staff it. However, our immediate future plans do call for workshop and work programs and upon their development we would certainly offer such services (along with our present services, psychologist, vocational counseling, social worker) to ex-mental patients and to the mental health program ..."

Ohio State University, Columbus: "My notion would be that probably sheltered work-

shops have offered more to this group than have rehabilitation centers. The Ohio Rehabilitation Center has not yet accepted a patient from this category as such, but it has no policy which would categorically deny services to such patients ...

"We maintain a part-time psychiatrist on this staff as well as a psychologist and two social workers. We insist on interpreting our psychiatric services as an adjunct to physical, social and vocational rehabilitation; however, one of our problems growing out of this fact has been the request for service in an increasing number of instances to people who frankly need psychiatric help, but for one reason or another do not choose to ask it from an avowedly psychiatric institution.

"I would feel that as sheltered workshops are developed, either in conjunction with rehabilitation centers or through the addition of professional rehabilitation services to those now available, that much more might be done for the mental patient."

#### PENNSYLVANIA

Home for Crippled Children, Pittsburgh: "We are *very, very* seriously exploring the possibility of inaugurating such services and are currently conferring with appropriate community persons, including university staff people to see how we might be of service. We are talking in terms of prevention as well as post-hospitalization services for children. At the moment it is no more than early, exploratory planning, but I think it infers an attitude."

Rehabilitation Center, Hospital of the University of Pennsylvania, Philadelphia: "As this is a teaching institution, we are *very much* interested in rehabilitation of the mentally ill. However, it is my opinion that centers for the physically disabled are not suitable for that type of program. First,



the usual professional staff is not trained adequately to treat these patients. Secondly, mixing the physically disabled patients with the mentally disabled will have adverse effects upon both groups.

"Ideally, centers should be established which serve the mental patient exclusively and which provide an integrated comprehensive approach.

"It is quite possible that as our program develops we can undertake this project. We have a University Rehabilitation Commission which is active and interested, thereby providing the ideal environment for developing resources.

"Available funds would hasten the process.

"As part of my community activities I have been working with a sheltered workshop in establishing a service for the mentally ill, so that I am well aware of the magnitude of the problem and the present lack of adequate facilities."

#### BRITISH COLUMBIA

G. F. Strong Rehabilitation Center, Vancouver: "The government of this province operates an excellent Provincial Mental

Health Center which provides rehabilitation services to those patients who can benefit from such services."

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Although the statistical data in this brief survey are too small for significant conclusions to be drawn, it seems that the qualitative experiences of the rehabilitation centers quoted above point strongly to the feasibility and desirability of including ex-mental patients in rehabilitation center programs (of which there are some 350 at the present time throughout the U.S.). Above all, the experience of 23 rehabilitation centers demonstrates that the ex-mental patient can not only benefit from rehabilitation services, including sheltered workshops, but that his co-mingling with other types of handicapped persons presents no obstacle or difficulty for others simultaneously involved in the rehabilitation process. Significant, too, is the fact that the lack of funds is frequently a critical factor in the inability of rehabilitation centers to develop, or expand, services to mental patients.

## If a child stammers

There is an old belief that children stammer because they think faster than they can talk. This is very nearly correct. Actually a child does much of his thinking in eagerness and excitement, and he has many feelings and frustrations that could never be put into words. And even if he could calm his feelings and try to think his way into speech, he would often lack the vocabulary to express himself. He would then encounter a speech block—a sort of road block in word-thinking.

Halting and repeating and backtracking are normal phases of speech in a child's developmental years, and the symptoms should cause no anxiety. This commonplace stuttering is nothing more than speech in the making. It is immature speech; it is trial-and-error speech. It is speech that is not yet organized into a pattern that the child can use and control. Yet children

differ in their natural fluency. In general, girls are more fluent than boys. But apart from sex, some children are highly skilled in speech and others are peculiarly inept. It is the inept children, of course, who stutter more when they are learning to talk. But usually these handicapped children develop a satisfactory degree of fluency, and in the long run they are not far behind the more skillful pacemakers.

A child learns speech by imitation—much of it, of course, unconscious. He learns the language that he hears, be it English or Chinese or Choctaw. And he learns good speech or bungled speech according to the manner in which the words are presented to him. He cannot learn good speech from the baby talk of other children; he learns only by hearing clear speech in the adult pattern. Twins talk poorly because they listen to each other. The only child in a family talks well because he listens to the mature speech of his parents. Actually few children have the opportunity of learning good speech by absorbing good

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Dr. Bluemel, a retired psychiatrist living in Englewood, Colo., is the author of several books on speech defects.

speech patterns. Most children catch their speech in much the same way as they catch measles—by being exposed to it.

The child is obliged to catch his speech because there is no natural division between words as he hears them. He is in much the same position as the beginning student who is learning a foreign language and can make nothing out of a running conversation. Yet the student understands short phrases, and the foreign words make sense when he hears someone say *bon jour*, or *guten Morgen*, or *buenos dias*.

It can be seen that the child has considerable difficulty in learning speech because the words come to him in telescoped form. Naturally his difficulty is multiplied if he has to learn two languages at once. His parents may speak German, while his playmates speak English. Or the family may emigrate just when he is beginning to learn his native language, and he is thrown into bewilderment by a new language he cannot understand.

Even when a child is learning a single language the learning process is seldom easy. In this developmental period, while the child is "making" his speech, he encounters stresses which tend to "unmake" it. His speech may seem normal enough during this period, yet it may break under the stress of excitement, fatigue or frustration. The resistance of speech to stress is somewhat like the resistance of ice to weight. Ice that is half an inch thick on a lake looks the same as ice that is four inches thick; but while the thinner ice will barely carry the weight of a man, the heavier ice will sustain the weight of an army. One cannot, of course, compare ice with speech, but it can be said that when speech is securely organized it can tolerate the weight of considerable stress.

The thinly organized speech of a child is easily broken by such common stresses as

the excitement of a party or picnic. Fluency is even more likely to break under the sustained excitement of Christmas festivities. Speech is often disturbed by the fatigue of travel, camping trips and other tiring activities. There are many experiences which overstimulate the child and disrupt his tranquility; but while most of these stresses have only a temporary disrupting influence there are some experiences which may have a lasting detrimental effect. Such, for instance, are the experiences of shock—the shock of a fire, a flood, a fall, an automobile accident or any misadventure which carries the semblance of disaster.

Less conspicuous influences also break a child's speech, and here we can include the sustained stresses of anxiety and frustration. The child's fluency may suffer under the stress of family discord, the daily fear of a harsh teacher, or the menace of a bullying playmate. Fluency may also be disturbed by the nervous nagging of anxious parents who constantly "correct" the child's speech and thus make him self-conscious and apprehensive. In speech, the area of stress is particularly broad, and the speech function may be disturbed and impeded by any severe or sustained stress which exceeds the child's uncertain tolerance.

The functional upsets in a child's life are not, of course, limited to speech. Stress may disturb a child's sleep, his appetite, his digestion, his bladder control and countless other functions. There are natural limits to the tolerance of stress—and this applies to the adult as well as the child. When these limits of tolerance are exceeded something is sure to give. The reaction may take the form of insomnia, night terrors, loss of appetite, vomiting, facial twitching and so on. The reaction may also take the form of stammering, the particular functional disorder that concerns us.

Though the speech disturbance of stam-



mering appears to be simple, it is, in reality, complex. The initial disturbance, the primary stammering, is an intermittent inability to talk—or to talk with accustomed fluency. And as if this were not enough, the primary stammering soon takes on a secondary phase. When the stammerer's speech becomes blocked he tries to force the utterance of his words, and he enters upon an unnatural phase of effort and struggle, and sometimes contortion. He may even use his fists and his larger body muscles in a futile attempt to articulate. Meanwhile, his breathing is disturbed, and he holds his breath or attempts to talk after exhausting air from the lungs. In primary stammering, the thinking process is already confused, but in secondary stammering the speaker becomes more disorganized as he tries frantically to escape his dilemma by searching for synonyms and round-about expressions. Phobia adds itself to the picture; the speaker now becomes fearful of difficult words and of ominous people and situations associated with his former speech frustrations. All of this secondary stammering is added to the primary speech disturbance, and the final predicament of the speaker may be severe and bewildering.

And now the question: How can speech impediments be avoided—the stuttering of speech in the making, and the stammering of speech in the unmaking? The stuttering of early speech, or pre-speech, is normal, and ordinarily it should not cause alarm. Yet the repetition and halting may be excessive, and the broken pattern of speech may turn out to be the forerunner of stammering. For this reason impeded speech cannot always be ignored. Nervous and excitable children often make and unmake their speech in alternating phases; when the unmaking predominates, stammering is sure to follow.

At this juncture in the child's life the

problem is to organize his speech—to organize it into a pattern of natural fluency. This procedure not only reduces the stuttering, but it safeguards the child against the subsequent development of stammering. The organizing process is, of course, nothing more than the learning process. To learn good speech the child must clearly distinguish the words that he hears. But commonly the words of adult speech run together—theyruntogetherlikethis. They run together like the conversation in French or German that we hear when we are traveling abroad. We can understand the child's dilemma in distinguishing speech sounds when we consider what a task it would be to read the morning paper if all the words were merged into an endless polysyllable. Yet this is the kind of polysyllable the child hears in adult conversation. To his inexperienced mind the words are all linked together in challenging confusion.

Here the child needs speech training in which the words are unlinked so that he can understand them. The parents can help the child by speaking slowly, clearly, and in short sentences. Thus by a process of ear-training they present a pattern of speech from which the child learns easily and naturally. In the natural steps of learning the child first hears words with unmistakable clearness. Then he remembers the words. Then he is able to think the words. Then he can say them. Admittedly this formula is oversimplified, but it emphasizes the logic and the necessity of ear-training. Of course the parents cannot engage in ear-training throughout the day, but they can speak in slow and measured phrases often enough to provide the child with a stable pattern of speech which he adopts for himself.

An agreeable form of ear-training consists in reading to the child from a storybook or picture book. Again the sentences are short and clear. "Once upon a time — there were

three bears – a papa bear – a mama bear – and a baby bear.” Here the child identifies the words, and he learns as he listens. Soon he will want to join in the “reading” as the game proceeds. Of course he follows the pattern very poorly while his speech is new; nonetheless he learns in his own way and in his own time. Meanwhile, he is not *taught* to speak. He is given a clear pattern of speech, and he does the learning by himself. When he makes mistakes he is not corrected; and when it is his turn to talk he is not interrupted.

Phonograph records can be used to promote the learning process, and they add considerably to the opportunities for ear-training. Recorded songs are as useful as rhymes and stories—provided the words are clear. The mother repeats a few words as a record is played, and the child eagerly joins in the talking game. Occasionally a radio or television program can be found that will supplement the records, though the speech will have to be clear and slow if it is to have ear-training value. Throughout, the sensory training is informal, and it takes the pattern of a game. Yet the games establish the function of speech in an unbreakable pattern, and they furnish the child with lasting fluency.

This process of “making” or organizing speech can also be used effectively when the child’s speech is in the process of “unmaking.” The speech function which has become disorganized must be repaired or reorganized. There is little need to pay attention to the stammering itself, for this is merely a symptom—like the spots in measles. In speech therapy the parents endeavor to re-establish the normal pattern of fluency. The child must hear and feel himself again talking normally, and he does this as he listens to slow and measured speech, and repeats the words or accompanies them. This repairing process should

be done early in the course of the speech disorder; otherwise, the abnormal speech may itself become established as a lasting pattern.

Meanwhile, of course, the disorganizing stresses in the child’s life must be identified. There may be too much activity and excitement and too little calm in the daily program. There may be too much competition for speech at the family table, and no one may be listening when the little fellow is trying to talk. Still worse, an older brother or sister may snatch speech away from him, and thus put him at a constant disadvantage. Whatever the disturbing stresses in the child’s life, they should if possible be removed.

Adequate bed rest is important for the child who is overstimulated and easily disorganized. When such disturbances as facial twitching, bed-wetting or stammering suddenly appear, the child can be helped by a few days of bed rest. The rest will be more beneficial if it is fortified with a sedative—given, of course, under medical direction.

A tranquil home is important for the nervous child, for it tends to establish the inward composure that is necessary to normal speech. Yet in the child’s developmental years, composure is easily lost and speech readily becomes disorganized. Fortunately, parents can safeguard the child in these situations. They can help him and guide him in the simple skills of word-thinking and thus they can assure him the fluency that he will need in daily living.

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KARL S. BERNHARDT, Ph.D.

FRANCES L. JOHNSTON

NAN FOSTER

MARGUERITE BROWN

## Attitude change in members of parent education courses

All educators must have faith in the educational process to bring about changes in the members of their classes. It is usually desirable, however, to have an adequate evaluation of the results so as to know both the extent and the nature of the changes produced. This is as true of parent educators as it is of any other type of teacher.

Many attempts have been made to measure the effect of participation in parent education courses. Some of the questions the parent educator seeks answers for are these: What attitudes in parents would seem to best foster healthy development in children? Does attendance at parent education groups encourage these attitudes? Does a

parent's attitude change as a result of attending a group and is the change in the best interests of his child?

The method most frequently used to get answers to these questions is the questionnaire, filled out at the beginning and end of a series of meetings.<sup>1</sup> The usual conclusion of such studies is that attendance at such groups does result in a change of attitude and further that the change is in a direction that parent educators would consider desirable.

However, the questionnaire method is not completely satisfactory. There is the suspicion sometimes that the members may try to give the answers that they believe the leader expects. Also, the questions asked are sometimes "leading" questions so that the answers may be more a reflection of a kind of verbal learning and not necessarily an indication of a change of attitude.

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All four authors are members of the staff of the Institute of Child Study of the University of Toronto.

<sup>1</sup> Examples of such studies are given in Monograph 17 published in 1939 by the University of Minnesota.



## Attitude change in parent education

BERNHARDT, JOHNSTON, FOSTER AND BROWN

The "Q" technique described by Stephenson<sup>2</sup> and used by Rogers<sup>3</sup> to measure personality change as a result of psychotherapy seems to offer the type of measure required. By this method it is possible to determine the degree of relationship between different sorts of statements. For example, the subject could be asked to sort the statements to conform with how he views himself as a parent, and with what he thinks an ideal parent is like. Then the "Q" can be calculated to indicate the degree of relationship between the two sorts. Or the sort at the beginning and the sort at the end of a course can be related to determine if there has been any change in how he views himself as a parent. If suitable material (statements) can be assembled, the details of administration are relatively simple. The subject sorts the statements (on cards) into a forced standard frequency distribution according to specific instructions. The relationship among various sorts can then be determined.

In the present study 684 statements about parenthood were collected from members of parent education groups. From this pool 50 statements were so selected as to provide a wide range of parental attitudes ranging from a high degree of adequacy to extreme inadequacy. This selection was made by the four authors individually and in consultation with each other. Each statement was carefully studied for relevance and for possible ambiguity or obscurity. The main concern at this stage was to get clear, easily understood, unambiguous expressions of parental attitudes in a wide range from the highly desirable to the highly undesirable.

These statements were used with a group of parents who were members of one or another of three parent education courses being conducted at our institute at the time. Although the three courses varied in content they were conducted by staff members

and were fundamentally similar in their philosophy of child training to that of the institute. Each course consisted of ten 2-hour meetings held weekly. The form of the session varied but was in the main a combination of lecture and discussion. The data reported here came from 39 group members for whom complete before and after sorts were obtained.

Each member was asked to sort the statements twice at the first meeting of the course and twice at the final meeting. On each occasion the statements were sorted first as a "self" sort and then as an "ideal" sort. For the "self" sort the statements were placed in a forced normal distribution of nine categories ranging from "most like myself" to "least like myself" as a parent. The "ideal" sorts used the same distribution but this time "most like" and "least like" were in terms of "what I think a parent should be." "Group ideal" values were obtained by combining the ideal sorts of all subjects. "Q" values were then calculated for the following: self 1—ideal 1; self 1—group ideal 1; ideal 1—group ideal 1; self 2—ideal 2; self 2—group ideal 2; self 1—self 2; ideal 1—ideal 2; self 2—ideal 1; self 2—group ideal 1; and ideal 2—group ideal 2. (The numeral 1 refers to the sort at the beginning and 2 to the sort at the end of the course.)

From this wealth of material—10 sets of "Q's" for each of the 39 members—some interesting conclusions can be derived. It can be seen that the people who come to parent education courses differ widely in the way they think of themselves as parents.

<sup>2</sup> William Stephenson, *The Study of Behavior: Q-Technique and Its Methodology*. Chicago, University of Chicago Press, 1953.

<sup>3</sup> C. R. Rogers and Rosalind F. Dymond, *Psychotherapy and Personality Change*. Chicago, University of Chicago Press, 1954.

If we can accept a difference between the "self" picture and the "ideal" picture as meaning that the individual feels inadequate as a parent, then we can say that approximately half the group felt inadequate; some others, with self and ideal pictures almost the same, felt adequate.

The range in "Q" values for the self 1—ideal 1 was  $-.11$  to  $.95$  with a median value of  $.58$ . This would seem to indicate that parents coming to parent education courses do so for a number of reasons. It might be possible to sort the parents into two groups, those with low Q's needing an increase in self-confidence and parental skills and those with high Q's who may need a different kind of experience designed to produce a more thoughtful and less complacent attitude.

Our main aim was to try to determine whether there was a change of attitude resulting from participation in the course. One indication of this would be a change in the magnitude of the "Q" in a comparison of the self 1—ideal 1 and the self 2—ideal 2 sorts. That is, do the self and ideal pictures become more alike or farther apart? If we accept a change of  $.1$  or more as significant, then we find that 18 (46%) show a change towards a greater similarity of pictures, 7 (18%) a change in the opposite direction and 14 (36%) show no significant change of this nature. However, when the two pictures are close together at the beginning (high Q's) there is less possibility of change towards greater conformity. The ten with the highest self 1—ideal 1 Q's showed no significant change in this direction, but three of the ten showed a significant change in the opposite direction—that is, less similarity between self and ideal pictures. On the other hand, nine of the lowest beginning Q's showed a change towards greater similarity in pictures, and presumably felt more adequate as parents after the course.

Participation in a parent education course does seem to be effective in bringing the self and ideal pictures closer together when they are far apart to begin with.

Was the change that occurred in the way the parents viewed themselves as parents or was it a change in their ideal picture of a parent? An inspection of the self 1—self 2 Q's indicates considerable change in the self picture during the 10 weeks of the course. These Q's ranged from  $.04$  to  $.87$  with a median Q of  $.69$ . The change in the ideal picture is less pronounced, the range of the ideal 1—ideal 2 Q's being from  $.25$  to  $.90$  with a median of  $.79$ . Nine of the group had a self 1—self 2 Q below  $.60$  while only three had an ideal 1—ideal 2 Q that low. Sixteen had ideal 1—ideal 2 Q's over  $.80$  while only nine had self 1—self 2 Q's of that magnitude.

These values would seem to suggest that attendance at a parent education course brings about a greater change in how the person views himself as a parent than in his picture of what a parent should be like. It may very well be that most of the subjects had a fairly adequate ideal picture of parenthood and needed very little change in this regard. This is indicated by a correlation of  $.95$  between the beginning group ideal and the final group ideal. And also when the group ideal was compared with a combined sort made by the three leaders of the parent education groups the resulting coefficient was  $.85$ , so that the picture of an ideal parent held by the members was very similar to that of the leaders. With the kind of people who come to these groups there seems to be very little need for education in parental ideals but rather for an emphasis on how to become more like the parent they think they should be.

An examination of the placement of the statements in the various sorts indicates considerable stability. For example, the stand-

TABLE 1

Summary of *Q* values for selected cases

CASE	$S_1I_1$	$S_1GI_1$	$I_1GI_1$	$S_2I_2$	$S_2GI_2$	$I_2GI_2$	$S_1S_2$	$I_1I_2$	$S_2I_1$	$S_2GI_1$
5	-.11	-.10	.71	.68	.68	.61	.04	.65	.56	.66
31	-.11	-.07	.83	-.06	.07	.87	.66	.86	.06	.12
45	.52	.32	.62	.20	.53	.59	.51	.45	.51	.61
44	.88	.78	.69	.91	.80	.79	.86	.84	.84	.78
20	.94	.79	.83	.49	.54	.56	.57	.58	.58	.51

ard deviations of the placements in the self sorts ranged from .27 to 1.86 and in the ideal sorts ranged from .67 to 1.57. Although considerable variation in placement of the statements in the self sorts is to be expected, if the variation in the ideal sorts is too great the statement is probably not a good one. An examination of the distributions of placement of statements in the ideal sorts indicated that only three of the 50 statements are questionable. These statements will be modified in the next application of the material.

A simple 5-item questionnaire was used at the end of the course. The results indicated that, as is usual, the members answered the questions in a manner complimentary to the course and the leaders. Of the 38 who completed the questionnaire, all but five said the course changed their attitude to their child; all said the course increased their understanding of children; all said the course increased their skill in guiding the child; all but five said the course changed their ideal of what a parent should be like, and 27 said the course did not produce any confusion about what to do when difficulties arise.

A correlation of total score on the questionnaire with the self 1—self 2 *Q*'s resulted in a coefficient of  $-.28$ . This would seem to indicate that the *Q*-sort technique is measuring something different from the more

direct questionnaire. We could speculate that the questionnaire provides an indication of a kind of intellectual change and the *Q*-sort taps a more basic attitudinal change.

A detailed examination of the results for a number of selected subjects was made. A brief summary of this examination is provided here to indicate how the material can be used to gain insight into what happens in individual cases in parent education. A summary of the *Q* values for these five cases is given in Table 1.

#### SUBJECT 5

This is a mother of three children attending her first parent education course. In the first sort her self picture is very different from her ideal, although her ideal is very similar to that of the whole group. At the end of the course her self picture has changed considerably and now conforms fairly well with her ideal and the group ideal. Her ideal picture has remained fairly constant as the self picture changed. We would expect that with her original self picture so different from her ideal picture before the course she felt inadequate as a parent, but that after the course as the two pictures are more nearly alike she now feels more adequate as a parent.

The nature of the change that has taken place can be seen by examining the change in placement of statements. Some details



are worth noting. She is now more aware of what her child is doing and nags less. She is less influenced by the way she feels and trusts the child more. She shouts at her child less and acts less on impulse. On the whole, she gets along better with her child. She seems to have a better understanding of her role as a parent, and it seems safe to conclude that the course has been very successful for her.

#### SUBJECT 31

This is a mother aged 50, with one child, attending her first parent education course. In the first sort her self picture is very different from her ideal, which conforms closely to that of the group. At the end of the course there is very little indication of change. Her self picture is now similar to the original and still far from her ideal. It would seem that the course had very little effect, and one could guess that she would feel about as inadequate after the course as before.

On the other hand, an examination of her answers on the questionnaire shows that she thinks the course changed her attitude, increased her skill and understanding and produced no confusion. One could speculate that the changes are rather superficial and wonder whether individual counseling, rather than a parent education group, would be more helpful.

#### SUBJECT 45

This is a mother of four young children, attending her first parent education course. There is moderate conformity of her self picture and her ideal at the beginning of the course. Some change is indicated as her two self pictures show only moderate similarity. There is even less similarity in her ideal pictures so that there has been change

in both self and ideal. It is difficult to tell whether the changes result in more or less adequacy as a parent.

The questionnaire shows that she thinks her attitude has changed and that her understanding and skill have increased but that the course produced some confusion as to what to do when difficulties arise. Perhaps this parent was looking for specific answers to problems and was not led to think through her problems in the light of principles. Again one could speculate that this parent needs a more prolonged participation in a parent education program to profit from it.

#### SUBJECT 44

This is the mother of two young children, attending a parent education course for the first time. At the beginning her self picture and her ideal picture are very similar although her ideal is only moderately similar to the group. There are only slight changes indicated at the end of the course, her ideal picture now being more like that of the group and her self picture very similar to her slightly changed ideal. There is no indication that she came to the group because of a feeling of inadequacy as a parent but rather that she, a "good" parent, came in the hope that she could become even better. Perhaps this indicates the necessity of providing parent education courses for different parental needs.

#### SUBJECT 20

This is the mother of one young child. At the beginning her self picture and her ideal picture were almost identical. At the end of the course her self and ideal were farther apart due to changes in both her self and ideal pictures. This seems to be the picture of a fairly complacent parent who, because

of the course, was led to change both her ideal of parenthood and her picture of herself. This illustrates another function of parent education—namely, to bring about a more thoughtful attitude and less complacency. One can hope that this kind of change would make for better parenthood even though it may be disturbing to the parent temporarily.

#### SUMMARY

The Q-sort technique promises to be a valuable way of assessing the effects of parent education programs. It seems to provide a method of tapping more fundamental attitudes and attitude change than the more direct questionnaire method.

As would be expected, parents come to parent education courses for a variety of reasons. Some come because they feel inadequate as parents while others come out of curiosity or to increase their knowledge of child development. It may very well be

that some method of sorting out members and providing different kinds of programs to meet different needs is indicated. The Q-sort technique may be one method of doing this.

At the present time the people who present themselves for parent education courses seem to need to learn how to become more like the parent they would like to be than to learn more about what the ideal parent is like. At least, it does seem to be clear that parent education courses such as those conducted at the institute are more effective in changing parent attitudes and behavior than in changing their goals and ideals.

This attempt to assess what happens to members of parent education courses is encouraging in that there are clear indications that change does take place and that it seems to be in the main in the desired direction. However, there are also indications that the program is not being effective with all and that some other procedure is called for in some cases.

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ALLEN HODGES, Ph.D.

DALE C. CAMERON, M.D.

## Characteristics of communities successful in organizing local mental health services

In a recent article<sup>1</sup> we reported on the impact of state grant-in-aid legislation in stimulating the development of community mental health services in Minnesota. The initial acceptance of the legislation and the willingness of inter-county units of government to finance the services has been striking. While our Community Mental Health Services Act of 1957 must be considered an important stimulus, the community dynamics and characteristics which culminate in the establishment of a local mental health center color the process of organization in ways deserving of study.

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Dr. Hodges is psychological consultant on community mental health services and Dr. Cameron is medical director of the Minnesota Department of Public Welfare.

<sup>1</sup> Hodges, Allen and Dale C. Cameron, "Minnesota's Community Mental Health Services," *MENTAL HYGIENE*, 43(1, 1959), 111-14.

Within a 12-month period five regional units encompassing 17 counties applied for state funds. Meetings were held, newspaper editorials written, mental health study committees appointed. In most instances total community resources were mobilized with the result that all 17 counties appropriated county tax funds to match state funds. In this development each community showed unique individual differences.

Three characteristics were observable, however, and appeared common to successful efforts within each community. It appears likely that these three community characteristics underlie the organizational successes so far experienced.

### WELFARE BOARD LEADERSHIP AND COMMUNITY INTERPRETATION

In 1953 the State Division of Social Welfare and the Division of Public Institutions



were consolidated. The Department of Public Welfare emerged, consolidating in one unit of state government all responsibilities centered around county welfare board operations and the total mental health program. The close liaison between these two service activities increased communication on all levels. Because of community respect for the county welfare boards' efforts to serve the needs of their clients, these boards today are some of the most valuable channels of communication to Minnesota citizens. In addition, in their services to their clients these boards encounter daily the social and economic aftermaths of mental illness and mental deficiency. This combination of awareness of need and knowledge of program planning places the boards in a position of strong leadership. Within all five successful areas the personnel of the county welfare boards have taken a major role in surveying community needs, serving as resource persons to interested groups, and planning the actual program.

### PLIABLE SECTIONALISM

In the five areas under consideration, each community firmly believes that within the whole state of Minnesota it is the most progressive and must be considered the best community in the state. This partisan pride is evidence, for example, in support of local athletic teams, pride in school building programs, and strong competitiveness in bidding for local industrial development. (At the time of this writing, state-wide studies related to the establishment of additional centers for higher education are underway. Three of the five areas that have established mental health centers already have colleges in their immediate geographic area and the remaining two are among the leaders in attempting to locate institutions of higher learning within their

areas. It appears that not only are developments occurring in planning local mental health facilities but these five communities are planning ahead in other areas as well.)

Flexibility and pliability are also present in these successful areas, tempering their intense community pride. Under provisions of the Community Mental Health Services Act a minimum population of 50,000 is required. With the typical Minnesota county having approximately 18,000 population, counties of necessity must band together. In one region, relations have been strained for many years because of the division of one county into two separate counties. Owing to their common recognition of community mental health needs, these two counties united cooperatively with several other smaller counties to establish a local mental health center.

Intense sectionalism definitely appears to be a necessary characteristic of successful communities, but with fluid boundary lines defining the geographic area to be served.

### EMERGENCE OF NATURAL LEADERSHIP

In all instances, our initial interpretation of the Community Mental Health Act has been on a broad educational basis upon invitation from interested groups such as PTA's, district welfare conferences, local mental health associations and service clubs. No concentrated effort was made to recruit support from community leaders or professional groups. Efforts were made, however, to enlist the support of the newspapers so that information could be broadly disseminated.

When invited to address interested groups the state consultants attempted to interpret the role of a local mental health center in the community and the realistic expectations that a community might have regarding the services of the center. The major

emphasis in interpreting the program was placed on the underlying philosophy of the program: Local Control with State Support.

With this initial structuring, successful communities demonstrated sufficient interest to invite resource persons from within their own community—such as welfare board social workers, physicians and ministers—to present their observations concerning the need for local mental health services. Guest speakers from the Department of Public Welfare, Minnesota Association for Mental Health, Department of Health, and University of Minnesota were invited to give a broader perspective of state and national thinking relating to the feasibility of the local mental health center as a community resource in promoting mental health.

Throughout this interpretative phase the leadership and creative thinking of this loosely organized, interested group evolved through certain respected spokesmen whose leadership in other civic programs had al-

ready been demonstrated. Contrary to the sometimes voiced opinion that most community leaderships are crusaders for mental health because of personal difficulties, leadership appeared to emerge from already established influential figures in the community whose civic responsiveness had been previously demonstrated.

#### SUMMARY

Certain behavioral characteristics of communities successful in planning for local mental health services have been discussed. While each of the five areas demonstrate individual differences in organizational procedure, three common characteristics are observable. The leadership of local welfare boards in interpreting the program in the community, strong sectional pride with fluid boundaries, and the utilization of previously established community leadership appear to be these three major influences in the development of community mental health services in Minnesota.

# Family structure and alcoholism

Alcoholism, like other forms of behavior defined as socially deviant by our culture, poses a particularly difficult adjustment situation for the family. The cultural norms governing the behavior of family members towards one another directly conflict with the prescriptions for behavior of members of the society in relation to social deviants. As a result family members are constantly in conflict over their adjustments. In addition, crises evolving from socially disapproved deviant behavior are left unstructured by the culture. The family facing this situation must resort to trial-and-error behavior in its attempts to control the deviant and to bring him back into line with social expectations. At the same time it is held at least partially responsible for his behavior. By definition a good and adequate family is one whose members behave in accordance with social expectations. Thus in its efforts to handle

the problems associated with deviancy the family labors under a pall of blame. Its members feel guilty, ashamed, inadequate and, above all, isolated from social support. Where the husband is the alcoholic this burden falls disproportionately on the wife who, in her own and in society's view, has failed in her major roles.

The situation of alcoholism is even more complicated by the discrepancy between the accepted stereotype of the alcoholic and the realities of alcoholism. Only an infinitesimal proportion of all alcoholics approximate the constantly inebriated, de-

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Dr. Jackson is research assistant professor of sociology in the psychiatry department at the University of Washington School of Medicine. The study from which she derives her observations was supported in part by the National Institute of Mental Health, the State of Washington Initiative 171 Funds for Research in Biology and Medicine, and the O'Donnell Psychiatric Research Fund.



socialized Skid Row bum, who is in a far-advanced stage of the disease. Most alcoholics, until well along in alcoholism, spend the greatest part of their time sober and handling their roles in a socially adequate manner. The discrepancy between the stereotype and the reality blinds the family to the nature of the situation for a prolonged period of time and interferes with constructive, planned behavior. The crisis mounts to considerable intensity before the family is able to comprehend that the alcoholic's behavior is involuntary and cannot be handled by any of the usual methods of social control. When the family arrives at this accurate perception of the situation, constructive reorganization usually occurs within a brief period of time.

Until this time the family's history is one of chameleon-like shifts in structure and member roles, in the alignment of relationships within the small family group and within the families of the parents. At any given stage of alcoholism the family's structure is related to the degree, duration and type of alcoholism, to the present state of the alcoholic (that is, whether he is drunk or sober) and to the type of concurrent subcrises, which usually accompany alcoholism. In addition, the family's behavior is conditioned by its relationships and action in earlier stages, which places limits on the actions it is possible for them to take in this stage.

Despite this, certain broad trends are observable which vary in content but not in broad outline from family behavior in the face of other types of prolonged and cumulative crises. The crisis begins as a series of acute crises, usually widely spaced in time, passes into a progressive type of crisis during which the emotional involvement and hostility expressed are diminished, and finally, if the family stays together, into an habituated crisis which is

minimally disrupted by the behavior associated with alcoholism. Secondary crises of both the acute and cumulative type also arise and go through stages similar to the over-all pattern.

There are distinct stages in the family crisis of alcoholism. Some families pass through all stages to a happy ending while others traverse only part of the route. Families also vary as to the length of time spent in any one stage. At first a family denies the existence of the problem and tries to retain intact the family's organization and role expectations, despite recurrent disruptions due to drinking. In the second stage the family makes frantic trial-and-error efforts to control the problem. The roles of family members are in a state of flux as an attempt is made to arrive at a division of labor which will make drinking unnecessary or impossible. Following this stage there is a downward slump in family organization. Roles are played with little enthusiasm. Relationships are progressively strained. Only minimal family functions are fulfilled. Finally, as some adaptive behavior is successful for the non-alcoholic segment of the family, reorganization commences and the family's structure is restabilized at a new level which cannot be disrupted by continuing alcoholism. Should the alcoholic recover, however, a new crisis is engendered and a still different type of family organization must be evolved.

At each of these characteristic stages roles are reshuffled among family members, changes occur in intra- and extra-family status and prestige; "self" and "other" images are restructured; and the degree and type of family integration, self-sufficiency and solidarity are altered. The family as a unit and the individual members tend to become progressively more isolated until the reorganization phase.

The alcoholic is isolated most of all, even after the family has moved in the direction of reintegration.

As alcoholism progresses, the status of the alcoholic in his family is steadily downgraded. Initially efforts are made to help him retain his position as father and husband and his status in relation to the community. While inappropriate drinking is still sporadic each incident is treated as an isolated unit of behavior. Husband and wife examine their relationship and the family organization in an effort to understand the causes of the incident. Family roles, routines and associations which are hypothesized as contributory are altered for a short time until the anxiety associated with the inappropriate drinking incident diminishes.

With each renewed drinking episode this process is repeated. The family members cover up for the alcoholic among themselves and outsiders. Excuses are made for his behavior; it is reinterpreted as normal; and the family begins to cut itself off from community situations in which it might become visible.

As the behavior continues with greater frequency and greater disruptive effects on the family routines, organization and functions, it is no longer possible to maintain the role expectations of father. The discrepancy between actual role performance and expected role performance is so great that the family must take some action to survive. Trial-and-error behavior in structuring the alcoholic's role and status begins and family members become preoccupied with this problem. Within a short period he is treated as an invalid, a sinner, an irresponsible adolescent, a child, a full adult male, a distant relative, a stranger, a criminal and a madman. The family, in turn, reshuffles the social distances between members with rapidity.

The effort seems to be to find the right combination for controlling father's behavior. During this stage almost no stable elements of family organization exist. Even the roles of children alter drastically. Probably the most obvious role of the father at this point is that of "major problem."

As none of these experiments proves effective morale deteriorates and disintegration sets in. Purposeful behavior is replaced by sheer survival actions; roles are played with little or no enthusiasm; family routines are not re-established; family functions are not fulfilled or are delegated to community agencies. Behavior is engaged in because it is tension-relieving rather than an aspect of an integrated role. Family members go their own ways. Insofar as it is possible to think of father as having a status in such a disorganized social group, he is "a bother."

In earlier stages his periods of prolonged sobriety mobilized the family towards reorganization. At this point sobriety gained with help from treatment agencies can still stimulate a rise in family morale and an attempt to come together again. At such times attempts are made to restore the family's original status structure.

As other crises multiply and drinking continues, now accompanied by other socially unacceptable behavior, there usually comes a point at which the wife is jolted enough to resume her role as mother and, gradually, to assume the roles of her husband. Family routines are re-established. She assumes authority over her husband and children and family life becomes structured. The children begin to play their roles within and outside the family with improved morale. Family relationships with the community are re-established and the family stabilizes with the mother at the head. The father's

status in the eyes of the whole family is that of the most recalcitrant child. The main attitude towards him is exasperation. The non-alcoholic segment of the family becomes a community status-seeking unit apart from and despite him.

After the reorganization, if the alcoholic fights against his low status or proves disruptive to family organization and functions, which is often the case, it is only a short step to his removal from the family. This may occur either through divorce or desertion.

Unfortunately, the last family crisis of alcoholism occurs only occasionally. If the alcoholic recovers and maintains his recovery for a time, the family may re-include him. Reorganization to restore him to his major family roles is often painful to family members who must relinquish aspects of their own roles to make a place for him again. After years of believing that if father became sober all problems would evaporate immediately, it is difficult for the alcoholic and his family to accept that reorganization of mutual expectations in line with the new realities, against a background of their experiences with each other, can evolve only slowly over a long period of time. For some years after recovery and after the resumption of full

participant in his family, the alcoholic holds his high status and is permitted to exercise his roles only on probation. Whereas recovery of the alcoholic may begin suddenly, the full reorganization of the family as a successfully functioning unit is a process which is prolonged.

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MELITTA SCHMIDEBERG, M.D.

RICHARD H. ORR, M.D.

# Psychiatric treatment of offenders

Today's problem of crime and juvenile delinquency is enormous. In 1951, J. Edgar Hoover estimated that crime costs the United States at least \$15,000,000,000 a year. Today the cost would be closer to \$20,000,000,000. These figures do not include an estimate of the cost in human misery and in productivity of almost 1,500,000 lost human beings, half of them children under 16.

The experience of the Association for Psychiatric Treatment of Offenders<sup>1</sup> has led to the conclusion that at least 25% of all offenders would benefit from psychotherapy administered as an adjunct to, but not as a substitute for, existing legal procedures. The program of APTO is geared to utilize the authoritative role of the court and of probation and parole services while the therapist attempts, through an educative or reeducative process, to help the individual to direct his energies into socially acceptable patterns.

This experience led to the conclusion that a program for treating selected offenders in a community setting offers great promise. Besides being a hopeful answer to the problem of recidivism of the rapidly increasing number of lawbreakers, therapy in the community is more humane and less costly. The extra-institutional therapy of APTO, for example, can treat six offenders for the \$2,500 yearly maintenance of a single inmate in a standard penal institution.

## GOALS OF THERAPY

The first goal of therapy is the cessation of law-breaking activities. This goal is put

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Dr. Schmideberg, a practicing psychiatrist, is clinical director of the Association for Psychiatric Treatment of Offenders, with offices in New York City. Dr. Orr, a physician, is director of research and chairman of the APTO executive committee.

<sup>1</sup> A non-profit organization founded in 1950 to afford psychiatrically-oriented treatment of offenders.

first for the very practical reason that unless these activities are curbed the patient, of course, cannot be permitted to continue therapy as a free individual and must be removed from the community to protect society. Naturally the therapist cannot and should not act as a policeman; however, he should coordinate his efforts closely with those of the probation officer, either directly or through APTO's set-up, especially in the first phases of treatment. This demand on the therapist is unique to APTO's system and requires that the therapist forego some of his traditional detachment. Neither the psychotherapist in ordinary private practice nor the therapist treating offenders in an institution must face this problem, for the former rarely treats a convicted offender whose activities may constitute a real threat to the community and the latter has to worry little about crimes his patient may commit while in the controlled environment of an institution.

For another reason, also, close cooperation between therapist and probation officer is essential in the first phases of treatment. The offender is rarely a willing patient. Often it is necessary for the probation worker to bring the patient to his first appointments, or the therapist may have to inform the probation worker that the patient is not showing up for appointments and enlist his aid in getting the patient to return. As therapy proceeds the patient should develop a willingness to see the therapist of his own volition. In fact, the development of motivation for treatment is one of the first indications that therapy is progressing satisfactorily.

The second goal is socialization, that is, the offender must become adjusted, or readjusted as the case may be, to the restraints and demands of living in a community. This process involves, as a minimum, the establishment of at least some social con-

tacts, however tenuous they may be, and the getting and holding of a job. The reluctance to get jobs and to work steadily is one of the central difficulties with most offenders. This symptom can be effectively treated only when the offender is in the community and is faced squarely with the necessity of applying for jobs and earning a living.

When these first two goals are achieved the patient is no longer an offender and becomes much like the patients seen by psychotherapists engaged in the usual office or clinic practice. Therefore, the third goal of therapy is the same as for non-offenders undergoing psychotherapy—the readjustment of the individual's personality to allow him to live in harmony with his culture and to enable him to be a useful and productive citizen.

In discussing the goals of therapy, the advantages of treatment in the community rather than in an institution have been touched upon; however, this matter is important enough to warrant further emphasis. Psychotherapy of an offender in an institution is, at best, highly artificial. The pressures and demands on him as an inmate of an institution are entirely different from those of a community. Even if he becomes well adjusted while in an institution, he is totally unprepared for the stress and strain of life outside. This one factor may well explain why efforts at psychotherapy in institutions have often been so disappointing, for whatever adjustment is achieved may break down soon after the offender is released. Furthermore, APTO believes that its system of treatment, taking place in the therapist's regular office rather than in a special setting or clinic for offenders, is an important factor in achieving rehabilitation.

Whether only the first goal, the first two goals or complete rehabilitation can be

achieved depends, of course, not only on the therapist's skill but also on the raw material with which the therapist must work and the support he can get from the patient's family and social milieu. Complete rehabilitation is not always possible, but it is always to be attempted.

## RESULTS OF THERAPY

The following are three case histories from the files of APTO which illustrate the problems of treating offenders and the rewards which can sometimes be obtained.

Curley, age 27, was a gangster and holdup man. He had a long record of 20 previous convictions for a variety of offenses, had spent two years in a reformatory and six and a half years in prison, and had been paroled for another 13 years. The patient was sent for treatment by a lawyer and was one of the few who came without outside pressure, though his long parole had a strong influence on him.

The patient was of superior intelligence and was intellectually interested in psychoanalysis. The fact that the therapist treated him on a level of intellectual quality made for easy conversation; and that he could have friendly contact with a professional, law-abiding person was important to him, as he had no friends. His intellectual interest was largely a rationalization for the fact that he needed help against a severe depression, feelings of depersonalization and tendency to drink.

Although the therapist gave some interpretations, she was careful to phrase them so that they did not evoke anxiety. It was always kept in mind that the main aim of therapy was to socialize the patient and stop any upheaval that might lead to uncontrollable antisocial acts, which in his case would have meant a very long prison sentence, and not just to elicit interesting

material. The treatment lasted about 60 sessions, over 9 months, and irregular contact was maintained over several years.

Follow-up (9 years): The patient is married, has several children, has worked steadily and lives a law-abiding life.

Lefty, age 13, was arrested several times for larceny and burglary and had a long record of delinquency. He had been treated unsuccessfully for two years elsewhere. He was referred to APTO as an alternative to immediate institutionalization, which had been recommended. The patient came unwillingly, accompanied by his mother. He was sullen and suspicious and remained silent throughout the whole interview.

The therapist's first task was to establish rapport. He did this by getting the boy's interest by discussing delinquent activities and by giving him the feeling that he might protect him against being sent away. He succeeded in that the boy came the second time on his own, but was uncommunicative. Slowly a relation was established by taking him out of the office for walks and to restaurants and movies, and by helping him with his innumerable difficulties.

Lefty had an unusually unfortunate home life. His mother was widowed, a thoroughly unhappy, embittered and hopeless woman. His brother was mentally defective and was living on relief. The therapist visited the patient occasionally at home and established some relation with the mother.

Gradually he succeeded in developing a genuine and deep attachment in the boy and in stopping his law-breaking activities. He helped him to get some part-time jobs but found no solution for the home situation. Lefty had about a year of regular treatment, and after that for several years maintained occasional friendly contacts.

Follow-up (6 years): He is now almost 20, has a girl, leads a normal life, and has worked for several years very satisfactorily.



Mary, age 23, narrowly escaped being sent to prison for persistent shoplifting. She was put on probation for three years, with the condition of making \$3,000 restitution, and was sent to APTO by her probation officer, who thought her in need of psychiatric care.

She was a good-looking girl with some education and personality. Her mother had died when she was a child and she was brought up by a stepmother with whom she got on badly. She married young to get away from home, but her husband turned out to be a homosexual who gradually deteriorated into becoming a homosexual prostitute. Mary started to drift, to take up with undesirable men, and to shoplift after her husband deserted her. When she came for treatment she was living with her child, who had become very difficult as a result of neglect. The father, stepmother and a younger brother also lived in the same cramped quarters under a great deal of strain, but there was no alternative to this living arrangement.

The therapist first tried to improve the immediate family situation, talked to the father and gave some help concerning the child. There was close cooperation between the probation officer and therapist. Mary slowly worked out her problems in a modified analytic therapy and began to settle down to normal life. She started seeing a young man who came from a very bad home background, had a criminal record, and was uncultured, but had certain good qualities. Mary's therapist also saw her boyfriend for a few therapeutic interviews and gave him some confidence and initiative. Mary's treatment lasted about six months, sessions being held once a week. She stopped when she was engaged to get married, but saw the therapist a few times later to keep in touch.

Follow-up (3 years): Both Mary and her husband are working, and the child has become more normal as the family situation has straightened out.

Of course, the outcome is not always as favorable as in these cases, but as more is learned of the basic psychology of the offender and as therapists become more experienced and skillful a higher percentage of salvage for useful life can be expected. These cases also illustrate the way APTO therapists work with the courts and probation personnel and how they achieve the three goals of therapy.

#### WHAT APTO CAN AND CANNOT DO

The APTO cannot solve the problem of delinquency by itself. However, it can mobilize the therapeutic resources of the New York area, and the local chapter of APTO can serve as a prototype for similar organizations in other large cities. In addition to making available to the community the skills of those therapists who have some experience with offenders but who are now in private practice and rarely, if ever, treat offenders, APTO can stimulate the interest of other therapists in seeing such patients and can train them in the necessary special techniques.

The research efforts of APTO are most important because so many offenders who are obviously in need of psychiatric treatment do not respond to or benefit from the usual psychiatric approaches. The APTO has for years studied methods of making unwilling patients amenable to treatment. We have already demonstrated, on a small scale, that this can be done, but it is essential to experiment further with yet other types of patients and to develop further approaches. Also, it is necessary to demonstrate to psychotherapists and to the public

on a more comprehensive scale that many offenders previously regarded as not amenable to therapy can be successfully treated.

At present only a small number of therapists are employed full- or part-time by the New York City courts and correctional institutions, and they are faced with an overwhelming case load. These therapists, with so many demands on them, often can make only diagnostic reports, because not enough time is available for actual treatment. Moreover, many of the patients who are seen cannot receive the individual attention necessary. The APTO can, by mobilizing experienced therapists who are now in private practice, greatly increase the number of patients treated, giving them and their families the full individual attention they need. Still more important, it can, by its training program, provide a

constantly increasing pool of trained personnel to draw upon.

The greatest hope that psychotherapy offers is that it will reduce recidivism, in which respect our present methods of correction have largely failed. A serious offender, before his career is finished by death, costs the community hundreds of thousands of dollars to apprehend, bring to trial, and maintain in prison for his repeated crimes. Surely, even when considered only in terms of dollars and cents, ignoring the more human values on which one cannot put a price tag, all logic dictates that we must try a more modern solution to the ever-increasing problem of crime when our conventional methods prove inadequate. Moreover, now is the time to begin this experiment, which promises so much at so little cost.

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M. B. HAMOVITCH, Ph.D.

GERALD CAPLAN, D.P.M., M.D.

PAUL HARE, Ph.D.

CHARLOTTE OWENS, R.N., M.P.H.

# Establishment and maintenance of a mental health unit

## A case history and general principles

The mental health specialist has acquired considerable importance in our society in recent years, first as a therapist and more recently as a consultant. Traditionally located in an office in private practice or in a social agency or clinic, he has moved

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At the time they wrote this article, the authors were on the staff of the family guidance center at the Harvard School of Public Health. Dr. Hamovitch, a social worker, was on a year's leave of absence as professor of research in the University of Southern California's school of social work. Dr. Caplan, a psychiatrist, directs the family guidance center and is associate professor and head of the mental health program in the department of public health practice at Harvard. Dr. Hare, a sociologist, is in Harvard's department of social relations, and Miss Owens is the center's public mental health nurse.

Their paper, on the origins and establishment of a mental health unit, is the first in a contemplated series of three.

out into a variety of settings and has taken on a range of responsibilities. While the public and professional groups such as teachers, nurses and welfare workers have come to accept the mental health specialist and to seek his services, there continues a certain amount of fear of and resistance to him. Increasingly, however, education and health departments are turning to these specialists for mental health services. From the standpoint of the specialist, the following questions arise: How should he become involved? What steps should be taken in introducing and maintaining a program in such settings? What kind of program should be established? What relationships are involved? How can the service be maintained? Very little has been written on this subject, mainly because there has been so little experience.



The purpose of this paper is to report on one such experience and to attempt to derive principles which may be helpful to others embarking upon similar undertakings. While it must be kept in mind throughout that the paper is based on one "case," we hope it has relevance to other groups, in other settings.

First, perhaps, it would be well to define some terms. *Mental health specialists* as used in this paper refers to psychiatrists, psychologists, social workers and mental health nurses. The "case" used as the basis for analysis refers to a mental health unit established under the auspices of a school of public health in a district office of an urban health department. This unit has been in operation for four years. Throughout its history it has had a dual function: (1) to demonstrate the feasibility of providing mental health consultation to public health nurses and to study the nature and purpose of the consultation; and (2) to study the impact of selected crises on the mental health of families.

#### ORIGIN OF REQUEST FOR PROGRAM

The antecedents of this particular project had their origin in an operating field training unit of a School of Public Health, located in a district office of an urban health department. At one time, an attempt had been made to set up a mental health unit that would provide direct services to patients as part of the training unit. This attempt was not successful, and at the time our story begins the director of the training unit was eager to reactivate some kind of mental health program. At the same time, the directors of a large foundation were interested in encouraging the development of community mental health programs and had approached the school with the idea of possibly providing a grant to develop a

plan. As a result, the school's division of mental health was asked to survey the situation, to advise on the feasibility of setting up a unit, and to recommend the program best suited to the situation. The forces behind the idea, therefore, were favorable.

A first principle may be noted here which, while not startlingly original, is worth reporting. A new program has much more chance of being accepted and utilized if the original idea comes from those who must have something to do with its administration and financing. Many instances can be cited where programs have failed, or certainly were made more difficult of achievement, because the initial motivation came from the mental health specialists, wanting to move into a situation and having the task of convincing people that the program was desirable. Under these circumstances there is apt to be an air of suspicion that the "experts" are trying to force something on a group on the notion that "we know what is best for you" or "please let us show you what we can do." Either way, the host agency is apt to be suspicious of and somewhat resistant towards the incoming group.

In this project the request came from "within" to a larger extent than is sometimes possible, putting the mental health specialist in a much more favorable position—that of invited guest rather than self-invited intruder.

#### THE INITIAL PHASE

The psychiatrist on the faculty of the school who was asked to come into the picture was careful from the outset to make it clear that he did not view the invitation as a commitment by either side. This reflects a second principle, namely, that an invitation to explore the possibility of introducing a new program should not be

construed as a firm commitment to implement any suggested program. Too often, experts who have been invited on a tentative basis have misconstrued the invitation as an endorsement, and have taken over—like “The Man Who Came to Dinner”—in such a breezy, authoritative manner as to frighten the hosts. It is just this practice which has made laymen in social agencies wary of “experts.”

In the case being presented the first approach was to obtain as much information about the situation as possible, and at the same time to seek sanction from key figures for any project that might be developed. As quickly as possible the psychiatrist established contact with all the key figures as he was able to determine who they were. The field training unit was located in a health unit shared by a number of agencies, including health department nurses, visiting nurses, a well-baby clinic, a dental clinic, a communicable disease clinic, sanitary engineers and a day nursery. All were possible units with which to work. The mental health specialist conferred with the key people in each of these groups and also with the line personnel, to learn what they were doing and the extent and nature of their possible interest in a mental health program. He also conferred with community leaders, such as the priest in one of the local parochial schools, to determine their receptivity to a mental health program.

A couple of principles must be kept in mind here. A newcomer to any area or program should, as quickly as possible, make himself known by and should get to know the community with which he wishes to work. Otherwise, some will feel they have been slighted by not being approached early, and may develop fantasies about the “stranger.” This is important, because sanction must be sought not only from the

group eventually served directly but from others who may possess the power to sabotage the best laid-out program if they are opposed to it. Seeing everyone quickly is a means of dissipating any stereotype individuals or groups might have of a “psychiatrist.” If they could see him, alive and human rather than sinister and evil, they might not be prey to fantasy as are many laymen regarding psychiatry. Therefore, they might be more ready to accept and even to utilize his services.

Another important principle underlying this activity is that the newcomer to a situation unless he orients himself thoroughly, may perceive only a portion of the problem and may possibly develop a distorted picture of it, leading to unwise decisions.

This, then, was an information-seeking, sanction-seeking, fantasy-allaying phase of the operation. One of the problems was to determine who were the key figures who should be seen and whose sanction was important. In this, the psychiatrist did very well with one exception—and the exception later nearly proved the undoing of the project before it could even get underway. This will be discussed a little later in the paper.

A further principle operating here was that the psychiatrist did not come with a preconceived plan which he was to execute by manipulating people and circumstances. He really had an open mind about the feasibility of a program and about its nature. His information-seeking, therefore, was not just a mechanical, going-through-the-motions type of operation; it was a genuine seeking for pertinent information. Too often in social planning we “pretend” we want help from community people, when we really are giving them the illusion of being helpful to us so that they can be persuaded to do our bidding—the “hidden agenda” idea.

In the case being reported in this paper the psychiatrist believed some kind of program might be desirable and he had some notions about different kinds of programs which might be appropriate; otherwise, there would have been no point in getting involved at all. But he had a sufficiently open mind about it so that the decision might be, at this point, that it would not be feasible or that another approach might be better than the one first thought of. Furthermore, there was no thought of "selling" a program. Selling might be all right under certain circumstances, but it did not seem appropriate here. As he talked to key people, the mental health worker made it abundantly clear on every possible occasion that he subscribed to the principle that any feasible plan must fit into the existing organizational and administrative structure of the unit and must interfere as little as possible with current activities. On the one hand this helped to counteract the interviewees' natural suspicion of an investigator who might write a critical report, and on the other it allowed him to focus the interview on a detailed appraisal of the organization of the daily work.

Another point which should be mentioned here is that the psychiatrist, in seeking sanction, conferred with the administrative heads of the health department in addition to the administrators of the local district office. From the former he sought global sanction, however, rather than approval of details. In other words, it was not necessary to obtain specific sanction for this project, because this was implied in the sanction that had already been given to the training unit. But a verbal kind of interaction was necessary to let the central administration see the mental health specialist and know first-hand that he was on the scene and involved in a program

already approved. Detailed sanction was sought at the local level on the details of the plan.

The principle here is that in negotiating contracts for new programs detailed sanction is necessary at the local or line level, with less detailed and more global sanction necessary at more central or higher echelons.

#### DEVELOPMENT OF A PLAN

In the course of the appraisal phase the psychiatrist had to decide which of the various possible goals for a mental health program in this setting appeared both valuable and practicable. The initial invitation from the field training unit had been quite vague as to goals. From the unit's point of view, the program should fit into the ongoing activities of the building in which it was located; it should be in line with the goals and philosophy of the School of Public Health (that is, it should embody the latest ideas on the control and prevention of illness and the promotion of health); it should afford opportunities for research and the teaching of students; and if possible it should be in line with the ambitions of the field training unit to improve the operations of the city health department as a whole.

The psychiatrist believed also, however, that any program should interest itself not only in the activities of the city health department staff in the building; but also in the activities of other agencies there and in the forces influencing the mental health of the community outside the sphere of operation of these units. This was in line with general community organization principles. However, it appeared very quickly that there was no single community in which this district office was located, but rather a whole series of communities with varying interests and focuses. It became obvious, too, that if the mental health



specialists attempted to establish relationships with all the different groups in the community the major portion of their time would be spent with groups other than the one being served directly. This did not seem feasible.

It was also clear that a number of the agencies in the community offered some kind of mental health services. To introduce a new program to compete with these would be to encroach on their activities and to increase the defensiveness of their personnel. It appeared, therefore, that we would be wiser to narrow the focus of the new program to the operations within the district health office building and to deal with external community affairs and issues only within this context. Since the Visiting Nurse Association already had its own mental health program, this narrowed the focus still further to the city health department staff. Of the latter, the public health nurses seemed the most interested in a new program. Strategically they were in the best position to provide information about people in emotional difficulties because they visited families in their homes during times of trouble. This therefore seemed the group upon which the program might initially best be focused. This primary focus was accepted only as an initial approach, however, and the way was left open for working with the physicians, dentists and sanitarians, if in the process of time they might be interested in collaborating in the program. Contact with other agencies in the building or outside was to be incorporated in the program only insofar as it facilitated collaboration with the health workers, and was not to be undertaken merely because it promised benefit to the mental health of residents in the area.

Two principles seemed to be somewhat in conflict here:

- Any new program should be concerned not only with an immediate group to be served but also with the wider community. This is in line with a point made earlier that a mental health program particularly needs to keep in mind the peripheral power groups, and perhaps has an obligation to involve them in an educational program.

- Another equally important principle, however, holds that if a new program is to be effective with any one group, activity must center on the group and not be diluted in efforts to spread available resources too widely. Furthermore, in selecting a group with which to work it is wise to choose first the group most willing to cooperate in a project.

In this instance it was decided that the second principle applied, and so the decision reported above was made.

It is worth noting further that the Visiting Nurse Association requested mental health consultation, but the psychiatrist decided against acceding to this request. This was done on the grounds of refusing to compete with an already existing service. He was thus making clear that he was not planning a spreading empire. To have accepted would have strengthened the stereotype of this "dangerous person," ready to reach out his tentacles to embrace anything that was available. Too often we become seduced by these requests for service when, in fact, they may be a means of testing the degree of our acquisitiveness.

The next question to answer was what would be the type and purpose of a mental health program which might be worked out in collaboration with the nurses. Findings so far indicated that the latter had contact with patients suffering from different gradations of emotional disturbance, that they had considerable experience in identifying at least the most obvious of these

conditions, and that they had some skill in handling them in their everyday work, either by some form of counseling or advice or by referral to specialist psychiatric or social work agencies. The program might thus have the goal of collaboration with the nurses for the secondary preventive purpose of early case-finding in order to provide screening, diagnosis and either treatment or referral; or it might aim at some type of primary prevention in the identifying of maladaptive responses to life's difficulties which were predictive of future psychiatric illness, and the instituting in such cases either of preventive intervention by psychiatric workers or of counseling and mental health promotional help by the nurses themselves under the guidance of psychiatric consultants. In both types of programs the alternatives seemed to be to use psychiatric specialists for direct work with patients identified and referred by the nurses or to use the specialists to influence the patients indirectly by helping the nurses deal more perceptively and skillfully with their problems.

A review of these suggestions, however, revealed that some aspects were in conflict with certain important forces which seemed to be operating in the nurses' culture. The most significant of these appeared to be the reluctance or ambivalence manifested by the nurses in referring any but the most disturbed cases to outside treatment and resources and even to the social worker in the building. It should be possible for a remedial psychiatric agency in the building to accept cases from the nurses and to treat them without taking the family from the referring nurse; but in practice this might prove difficult, and in any case, especially at the beginning of a new program, rivalrous fantasies might develop, to the detriment of the relationship between the two groups.

It was clear that the nurturing and safe-

guarding of good relationships between the mental health workers and the nurses must be the fundamental goal of any program which wished to operate in the partnership and to survive. It seemed, therefore, that in the initial stages at least the program should not include a treatment clinic which involved removing a nurse's patients from her traditional professional life space to a psychiatrist's office, from which the nurse would be excluded. Further support for this was provided by the idea that if relationships between the nurses and the mental health worker ran into difficulties, which was quite a likely possibility, and if these difficulties focused upon the management of a patient for whom the mental health workers had professional responsibility as a treatment case, they would not be as free as they might otherwise like to be to cater to the nurse's difficulties and to be guided by her felt needs of the moment, since they would have to focus primarily on the needs of their patient.

It was believed that interaction between the two groups of workers must be the basis for building a partnership. The idea emerged, therefore, that in order to build this partnership with maximum security and with least difficulty a program should be planned which would allow the rate of interaction and the content of communications between the two groups to be constantly adjusted to the current attitudes of the nurses. In other words, the program should develop at a rate which could be tailored to the growth of the emotional bonds between the nurses and the mental health workers, and to the nurses' increasing interests and insights in mental health matters. Moreover, the content of the interactions should be chosen in such a way that it should interest the nurses and yet should not arouse resistance and defensiveness either because it would be too un-

familiar or because it would be emotionally more burdensome than they could easily cope with at that stage. A program fundamentally designed to avoid arousing resistance must, however, avoid the other big danger—namely, of reducing interactions to a minimum by discussing only pleasant, interesting, harmless topics, which would result in the building up of friendly relationships of a social nature between the two groups but not a useful working partnership to achieve serious and profitable goals.

A principle was followed here which is frequently overlooked in planning new programs. Too often we adhere to sound practice in establishing the proper relationships, in learning about the community and the group we wish to serve, in keeping channels of communication open, and so arrive at a sound decision that a program would be acceptable and feasible—only to fail to see ahead and prepare for possible future complications. Here it was apparent that the nurses would accept a mental health program now; but what of the future? Our knowledge of the nurses' culture would seem to foretell that eventually there might be problems and that it would be wise to set up a program which could survive these problems, rather than assume that acceptance now would mean acceptance in the future.

From these considerations the outlines of a plan began to take shape. Instead of using the referral of patients for psychotherapy as a vehicle for collaboration, we might find it possible to stimulate the requisite rate of interactions of appropriate content by involving the nurses and the mental health workers in the planning and execution of some sort of study. The content could be chosen so that it dealt with issues which interested the nurses and yet did not particularly disturb them, and which also interested the mental health

workers. If possible, the study should be so formulated that it dealt with certain of the nurses's patients, but the choice of patients to be investigated should be a very simple matter as far as the nurses would be concerned. The study should require that the nurses continue to treat patients as before, and if possible it should not involve any therapeutic service for the patients by the mental health workers. Since different members of the nurses' group would vary in their readiness to collaborate and since at any particular time some nurses might feel temporarily negative in their relationships with the mental health group, the study design should, if possible, be flexible enough so that cases could be chosen from such districts and in such numbers that only the currently receptive nurses need be involved; or if a nurse in a negative phase were to be asked to collaborate, this should be by design in relation to her attitudes and not be dictated by the needs of the research.

Finally, this joint study should be used as a departure point for any other collaborative endeavors in the mental health field for which the nurse might from time to time express a need. The door could always be left open for consultation with specialists about any of the nurses' daily work problems of mental health significance, and eventually the collaboration might move on to the utilization of the mental health workers for direct preventive service to patients, once a stable, unambivalent working partnership had been consolidated.

#### FORMULATION OF A PROPOSAL AND SECURING OF NECESSARY SANCTION

Having decided tentatively on a plan, we had next to get reactions to it from those key people whose sanction was important to the operation of any plan. First, clear-



ance was obtained from the head of the Division of Mental Health. Next to be approached were the directors of the field training unit, who had extended the invitation initially. Then to be involved was the head of the Department of Public Health Practice of the school. All of these individuals agreed with the general plan presented. It was agreed further that the program should be independent of the field training unit, to allow for development at its own pace. Out of this grew the idea for a special grant from the foundation which had encouraged the establishment of such a program.

Before proceeding to form a proposal, informal talks were held first with the supervisor and assistant supervisor of nurses to discuss possible study areas. Then all the nurses in the center were called together to hear the tentative proposal.

This was in accord with an important principle—of involving line workers actively in any new proposal before final decisions are made rather than presenting them with a *fait accompli*. Too often, again, we do well in involving appropriate personnel in the planning of a program, but when we have arrived at some tentative conclusions we go ahead with them in final form without checking back with these people to get their reactions and without being prepared to modify our proposals before putting them into operation. The nurses were clearly impressed with the fact that the psychiatrist had fulfilled his promise on this point and a much more trusting atmosphere was established than would otherwise have been the case. We also reported back to other groups which had been approached for ideas, to assure their friendliness toward the project even though they would not be directly involved in the operation.

Much of the work of obtaining sanction

for the plan from the various individuals and groups whose approval was necessary for its acceptance had already been accomplished by involving them actively in its details, so that by the time the project was committed to paper they felt a personal investment in it. This process had been consolidated by reporting back to them, which gave them an opportunity to think through in a concrete manner how the program would affect their interests and to suggest modifications in those details which they felt might not fit too well into their existing activities. Such sanction as had been obtained in this way was, however, of an informal nature, which meant that it did not specifically commit the individual or the group to the support of the program, and it was important that a formal act of sanction should be explicitly undertaken to accomplish this. It was therefore necessary at this stage to approach each of the authority groups involved and formally request their approval of the proposed program.

It was in thinking about these authority groups that the psychiatrist ran into the trouble hinted at earlier. One key authority in an allied area was not approached in the course of these negotiations because his relevance and the relevance of his institution to the project were not clear. It turned out, however, that this person was an important community leader whose opinion was now solicited in regard to the acceptability of the new program. Because he had not been involved earlier, he knew little about the proposal and was somewhat bewildered because he had not been consulted from the outset. Behind the scenes he raised some serious questions about the project and its director. This delayed formal approval of the project for some time, and in fact for a while the fate of the project was in considerable doubt. The dif-

ficulty was overcome finally, and the extra clarification led eventually to the building up of firm collaborative relationships between the institution and the project. But the experience demonstrated the principle that it is important to identify and involve all of the key people directly or indirectly related to a proposal, if a proposal is to have all the necessary sanction for its success.

## THE PLAN

The final program as presented to the foundation for approval, and which was approved, consisted of the following possibilities:

- Consultation with members of the health unit staff on mental health problems in any area of their work, to advise on practical policy in any particular case and to increase a staff member's knowledge of mental health implications and mental health techniques.
- Training of staff members of the health department by systematic courses of group instruction.
- Study of emotional problems of selected families in the area, to work out techniques for preventing emotional disorders. Such techniques were to include both those suitable for mental health workers and also for public health workers. In this study the public health workers, in particular the nurses, were to be involved in order to give them an opportunity to participate in an active learning process.
- Teaching of students of the School of Public Health and the Medical School.

The staff proposed for the project was to include a half-time psychiatric director, a psychiatric consultant, a full-time psychiatrist, a social casework consultant, a mental

health consultant nurse and two full-time secretaries. Liaison was to be established with a number of agencies and other projects. These included a mental hospital discharge study, a human relations service, appropriate people in the School of Public Health, and other agencies within the building.

From the outset it appeared that the project had two major functions: to provide a consultation service to the nurses and to undertake research. These were seen as complementary, but it was recognized from the start that there might be some conflict between the two. Research was to have a place of its own and was to stand on its own merits; at the same time, it was to be used as a device for establishing proximity with the nurses so that consultation could be encouraged and facilitated. Wherever the research interfered with the establishment and maintenance of relationships between the mental health workers and the nurses, however, it was felt that the service aspect should take precedence and the research should be modified to reduce the interference as much as possible. This became somewhat of a problem throughout, and is probably inherent in any situation where research and service are so closely interrelated. However, it should be noted that the problem is primarily one for the workers involved rather than for one deterring the success of either aspect of the project. While the caliber of the service and the research might be affected, perhaps even more serious was the possibility of role conflict for the workers involved.

## SUMMARY

In this paper an attempt has been made to look at a case history of the establishment of a mental health unit in order to note

certain principles which might have relevance for others contemplating similar undertakings. The material was based on one case only, and the principles which emerged are not necessarily original or dramatic. However, it was possible to

identify and illustrate what seemed to be a number of sound procedures in the establishment of a mental health unit. It is hoped that these will be of some value to others contemplating similar undertakings in other settings.

#### A LITANY FOR SICK SOULS

To those who limp among us,  
Speaking our common tongue, and only  
half suspecting  
The meaning's different:  
For when they say *love* they never felt it  
theirs

And never having it, they cannot give it . . .

To those puzzled, perverse souls  
Dear Lord, Bring Healing!

To those who dam themselves a pool  
Away from Thy living tides,  
A pool for ever-same and ever-self reflecting . . .

To stagnant, slime-choked souls  
Dear Lord, Bring Healing!

To those who hide themselves  
From Thy common blessing light of day  
In caves where only one may huddle,  
And each must paint his devil on the wall  
To quake before . . .

To Those, Dear Lord, Bring Healing!

To those who cannot freely move  
Through opening gates of paradox which  
mark Thy realm—

Those who forever hammer at their brain-  
walls

Demanding Thy reason; losing theirs  
In echoes they mistake for answers . . .

Dear Lord, To Those Bring Healing!

—HAZEL KUNO



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BENJAMIN MALZBERG, Ph.D.

# Mental disease among Negroes

## An analysis of first admissions in New York State, 1949-51

*Scientific progress may be furthered by the discovery of differences in the mental health or illness of people that are related to the differences in conditions under which they live. . . . Anything that facilitates the exchange of knowledge about people and the way they live and behave may further the understanding of mental health in any one country.*  
—George S. Stevenson, M.D.\*

According to the census of 1910 there were only 134,191 Negroes in New York State at that time; they made up 1.4% of the total population. The Negro population increased by almost 50% between 1910 and 1920. By 1920 they numbered 198,488 and

made up 1.9% of the total population. A far greater increase occurred during the next decade. The Negro population included 412,814 in 1930, or 3.3% of the total. This was the period of the first great migration of Negroes from south to north, after the first World War. Since 1930 the Negro population has continued its rapid increase. It grew to 571,221 in 1940, or 4.2% of the total, and reached 919,679 in 1950, or 6.2% of the total. Thus, between 1910 and 1950 the Negro population of New York State increased almost seven-fold, compared with an increase of only 55% in the white population.

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Dr. Malzberg is the principal research scientist for the Research Foundation for Mental Hygiene in Albany, N. Y. The study reported here was supported by a research grant from the National Institute of Mental Health.

\* *Mental Health Planning for Social Action* (New York, McGraw-Hill Book Co., 1956), 317-18.

As a result of these increases in the population there were corresponding increases in the number of annual first admissions to the New York civil state hospitals. The earliest data for Negroes are for 1914. There were 202 Negro first admissions dur-

ing that year, or 126 per 100,000 estimated Negro population. By 1940 this had increased to 1,160 annual first admissions, or a rate of 203 per 100,000. During this same period the corresponding rates for the white population increased from 64 in 1914 to 92 in 1940.

Thus, over a period of 26 years the rates of first admissions to the New York civil state hospitals were substantially higher for Negroes than for whites. It is therefore of great interest to examine the data for 1950 to see whether the great increase in the Negro population was accompanied by significant changes in the trend of first admissions. Primarily because of low economic status there are very few Negro admissions to private hospitals for mental disease in New York State. However, there are a substantial number of admissions to these hospitals from the white population. Hence, it is necessary to make comparisons on the basis of admissions to *all* hospitals for mental disease.

This study consists, therefore, of first admissions to all mental hospitals in New York State from October 1, 1948 to September 30, 1951. The mid-point of this period, April 1, 1950, is the date of the census of population. In conjunction with the census we shall compute average annual rates of first admissions during this period for Negroes and whites in New York State.

Previous studies have shown striking differences in rates of hospitalized mental diseases among the white and Negro populations of New York State.<sup>1</sup> In the first place, there is a great numerical excess of such diseases among Negroes. This is true of all the numerically important groups of psychoses. It is especially significant, however, with respect to general paresis and alcoholic psychoses. In these groups of mental disorders, which are primarily of social and environmental origin, the annual

rates of first admissions among Negroes exceed those of the white population in ratios of 6.7 to 1 and 3.8 to 1 respectively. There are further differences, such as the relative sex distributions of the rates. In general, differences between Negro males and females are relatively greater than those among whites.

In view of such important differences it is desirable to learn whether these trends continued during the decade 1940-50, and how they were influenced by the growth of population during that period.

During the three years from October 1, 1948 to September 30, 1951, inclusive, there were 6,167 Negro first admissions to all hospitals for mental disease in New York State. Of this total 2,789, or 45.2%, were diagnosed as dementia praecox. The second largest category, psychoses with cerebral arteriosclerosis, accounted for only 781 first admissions, or 12.7%. The alcoholic psychoses and general paresis followed in order of frequency. The former accounted for 534 first admissions, or 8.7%, the latter for 475 cases, or 7.7%. This distribution differs significantly from that of the previous decade.<sup>2</sup> During 1939-41 general paresis accounted for 14.8% of the Negro first admissions, the alcoholic psychoses for 11.3%. Together they accounted for 26.1% of the total, compared with 16.4% during 1949-51. Dementia praecox, on the other hand, increased from 29.2% of the total during 1939-41 to 45.2% in 1949-51.

The average annual rate was 223.5 per 100,000 Negro population. Dementia praecox presented the highest rate, 101.1 per 100,000. Other groups with significantly

<sup>1</sup> For example, "Mental Disease among Negroes in New York State, 1939-41," by Benjamin Malzberg, in *Mental Hygiene*, 37 (July, 1953), 450-76.

<sup>2</sup> *Ibid.*

TABLE 1

*Negro first admissions to all hospitals  
for mental disease in New York State, 1949-51,  
classified according to mental disorder*

MENTAL DISORDERS	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis .....	313	162	475	9.8	5.4	7.7	24.8	10.8	17.2
With other syphilis of cen- tral nervous system....	39	43	82	1.2	1.4	1.3	3.1	2.9	3.0
With epidemic encephali- tis .....	4	—	4	0.1	—	0.1	0.3	—	0.1
With other infectious dis- eases .....	17	15	32	0.5	0.5	0.5	1.3	1.0	1.2
Alcoholic .....	365	169	534	11.5	5.7	8.7	28.9	11.3	19.4
Due to drugs or other ex- ogenous poisons .....	10	5	15	0.3	0.2	0.2	0.8	0.3	0.5
Traumatic .....	45	10	55	1.4	0.3	0.9	3.6	0.7	2.0
With cerebral arterioscle- rosis .....	362	419	781	11.4	14.1	12.7	28.6	28.0	28.3
With other disturbances of circulation .....	11	25	36	0.3	0.8	0.6	0.9	1.7	1.3
With convulsive disorders	83	47	130	2.6	1.6	2.1	6.6	3.1	4.7
Senile .....	99	203	302	3.1	6.8	4.9	7.8	13.6	10.9
Involuntional .....	29	93	122	0.9	3.1	2.0	2.3	6.2	4.4
Due to other metabolic, etc., diseases .....	12	19	31	0.4	0.6	0.5	1.0	1.3	1.1
Due to new growth.....	5	5	10	0.2	0.2	0.2	0.4	0.3	0.4
With organic changes of nervous system .....	26	11	37	0.8	0.4	0.6	2.1	0.7	1.3
Manic-depressive .....	12	36	48	0.4	1.2	0.8	1.0	2.4	1.7
Dementia praecox .....	1,400	1,389	2,789	43.9	46.6	45.2	110.8	92.9	101.1
Paranoia and paranoid conditions .....	8	9	17	0.3	0.3	0.3	0.6	0.6	0.6
With psychopathic person- ality .....	118	87	205	3.7	2.9	3.3	9.3	5.8	7.4
With mental deficiency..	96	96	192	3.0	3.2	3.1	7.6	6.4	7.0
Psychoneuroses .....	50	42	92	1.6	1.4	1.5	4.0	2.8	3.3
Undiagnosed .....	24	24	48	0.7	0.8	0.8	1.9	1.6	1.7
Without psychosis .....	22	18	40	0.7	0.6	0.6	1.7	1.2	1.5
Primary behavior disor- ders .....	38	52	90	1.2	1.8	1.4	3.0	3.5	3.3
TOTAL .....	3,188	2,979	6,167	100.0	100.0	100.0	252.3	199.2	223.5



high rates were psychoses with cerebral arteriosclerosis, 28.3; alcoholic psychoses, 19.4; general paresis, 17.2; and senile psychoses, 10.9. There were the usual sex differences. Males had higher rates of dementia praecox, alcoholic psychoses and general paresis. Females had higher rates of senile and involutional psychoses.

The relative distribution of the mental disorders was markedly different for the white population. Dementia praecox was again the leading category, but it accounted

for only 26.9% of the total, compared with 45.2% for Negroes. Psychoses with cerebral arteriosclerosis and senile psychoses accounted for 19.4% and 13.9% respectively of the white first admissions, thus representing a third of the total, whereas these groups represented less than 20% of the Negro first admissions. On the other hand, the alcoholic psychoses accounted for 5.3% of white first admissions, compared with 8.7% for Negroes. The difference was especially marked in connection with general

TABLE 2

*Negro first admissions to all hospitals for mental disease in New York State, 1949-51, classified according to age*

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
5-9 .....	19	5	24	0.6	0.2	0.4	18.9	4.9	11.8
10-14 .....	80	100	180	2.5	3.4	2.9	91.4	110.1	101.0
15-19 .....	198	204	402	6.2	6.8	6.5	246.0	212.8	227.9
20-24 .....	441	287	728	13.8	9.6	11.8	422.6	193.0	287.7
25-29 .....	494	374	868	15.5	12.6	14.1	366.4	216.3	282.1
30-34 .....	375	339	714	11.8	11.4	11.6	314.9	215.5	258.3
35-39 .....	304	360	664	9.5	12.1	10.8	259.3	237.2	246.8
40-44 .....	284	229	513	8.9	7.7	8.3	277.4	190.0	230.1
45-49 .....	200	176	376	6.3	5.9	6.1	222.3	177.3	198.7
50-54 .....	174	175	349	5.4	5.9	5.7	249.6	243.1	246.3
55-59 .....	145	115	260	4.5	3.9	4.2	324.7	242.8	282.6
60-64 .....	114	136	250	3.6	4.6	4.1	383.1	383.9	383.4
65-69 .....	134	139	273	4.2	4.7	4.4	615.7	471.3	532.6
70-74 .....	86	120	206	2.7	4.0	3.3	715.8	720.7	718.6
75-79 .....	68	87	155	2.1	2.9	2.5	1,252.3	850.4	989.8
80-84 .....	41	83	124	1.3	2.8	2.0	1,752.1	2,057.0	1,945.1
85 or over....	29	46	75	0.9	1.5	1.2	1,933.3	1,518.2	1,655.6
Unascertained	2	4	6	0.1	0.1	0.1	-	-	-
TOTAL .....	3,188	2,979	6,167	100.0	100.0	100.0	252.3	199.2	223.5

TABLE 3

*White first admissions to all hospitals  
for mental disease in New York State, 1949-51,  
classified according to mental disorder*

MENTAL DISORDERS	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 WHITE POPULATION		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis .....	443	178	621	1.8	0.7	1.2	2.2	0.8	1.5
With other syphilis of central nervous system.	60	24	84	0.2	0.1	0.2	0.3	0.1	0.2
With epidemic encephali- tis .....	43	40	83	0.2	0.2	0.2	0.2	0.2	0.2
With other infectious dis- eases .....	73	41	114	0.3	0.2	0.2	0.4	0.2	0.3
Alcoholic .....	2,139	578	2,717	8.6	2.2	5.3	10.5	2.7	6.5
Due to drugs or other ex- ogenous poisons .....	68	129	197	0.3	0.4	0.4	0.3	0.6	0.4
Traumatic .....	256	41	297	1.0	0.2	0.6	1.3	0.2	0.7
With cerebral arterioscle- rosis .....	5,135	4,799	9,934	20.7	18.1	19.4	25.2	22.6	23.9
With other disturbances of circulation .....	144	142	286	0.6	10.5	0.6	0.7	0.7	0.7
With convulsive disorders	315	247	562	1.3	0.9	1.1	1.5	1.2	1.4
Senile .....	2,684	4,456	7,140	10.8	16.8	13.9	13.2	21.0	17.2
Involuntional .....	1,513	3,365	4,878	6.1	12.7	9.5	7.4	15.8	11.7
Due to other metabolic, etc., diseases .....	92	166	258	0.4	0.6	0.5	0.4	0.8	0.6
Due to new growth.....	133	119	252	0.5	0.4	0.4	0.7	0.6	0.6
With organic changes of nervous system .....	189	146	335	0.8	0.6	0.7	0.9	0.7	0.8
Manic-depressive .....	778	1,505	2,283	3.1	5.7	4.4	3.8	7.1	5.4
Dementia praecox .....	6,714	7,088	13,802	27.1	26.7	26.9	33.0	33.4	33.2
Paranoia and paranoid condition .....	149	128	277	0.6	0.4	0.5	0.7	0.6	0.7
With psychopathic per- sonality .....	426	278	704	1.7	1.0	1.4	2.1	1.3	1.7
With mental deficiency..	359	373	732	1.4	1.4	1.4	1.8	1.8	1.8
Psychoneuroses .....	1,442	2,030	3,472	5.8	7.7	6.8	7.1	9.6	8.3
Undiagnosed .....	178	103	281	0.7	0.4	0.5	0.9	0.4	0.7
Without psychosis .....	1,200	443	1,643	4.8	1.7	3.2	5.9	2.1	3.9
Primary behavior disor- ders .....	264	121	385	1.1	0.4	0.7	1.3	0.6	0.9
TOTAL .....	24,797	26,540	51,337	100.0	100.0	100.0	121.7	124.9	123.4

# Mental disease among Negroes

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TABLE 4

*Average annual rates of first admissions among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
under 10.....	7.9	2.1	5.0	5.1	3.4	4.3	1.54	0.62	1.16
10-14 .....	91.4	110.1	101.0	33.6	20.2	26.7	2.72	5.45	3.78
15-19 .....	246.0	212.8	227.9	173.8	141.8	156.6	1.42	1.50	1.46
20-24 .....	422.6	193.0	287.7	298.3	151.9	208.3	1.42	1.27	1.38
25-29 .....	366.4	216.3	282.1	291.2	188.4	230.0	1.26	1.14	1.23
30-34 .....	314.9	215.5	258.3	331.0	209.5	262.7	0.95	1.03	0.98
35-39 .....	259.3	237.2	246.8	291.5	207.4	245.9	0.89	1.14	1.00
40-44 .....	277.4	190.0	230.1	308.2	202.0	254.4	0.90	0.94	0.90
45-49 .....	222.3	177.3	198.7	389.5	263.2	325.8	0.57	0.67	0.61
50-54 .....	249.6	243.1	246.3	460.1	250.3	352.5	0.54	0.97	0.70
55-59 .....	324.7	242.8	282.6	454.9	372.1	412.0	0.71	0.65	0.69
60-64 .....	383.1	383.9	383.4	583.5	477.6	530.5	0.65	0.80	0.72
65-69 .....	615.7	471.3	532.6	883.7	677.8	766.7	0.70	0.70	0.69
70-74 .....	715.8	720.7	718.6	1,208.0	749.2	937.5	0.59	0.96	0.77
75 or over....	1,488.7	1,248.9	1,332.6	1,644.6	1,685.9	1,671.1	0.91	0.74	0.80
TOTAL	252.3	199.2	223.5	272.8	193.2	229.6	0.92	1.03	0.97

paresis, which accounted for only 1.2% of the white first admissions, compared with 7.7% of the Negroes.

The average annual rate was 123.4 per 100,000 white population. Dementia praecox was most frequent, with an average annual rate of 33.2. Psychoses with cerebral arteriosclerosis, senile psychoses and involutional psychoses followed with average rates of 23.9, 17.2 and 11.7 respectively. Average rates for the alcoholic psychoses and general paresis were 6.5 and 1.5 respectively, both significantly lower than the corresponding rates for Negroes.

The differences between Negroes and whites thus appear to be of a quantitative rather than of a qualitative order—that is,

the several groups of mental disorders all appear among both races, though in differing relative frequencies.

Between 1930 and 1940 there were marked increases in average annual rates of first admissions among Negroes. However, this was reversed in 1950. The general rate fell from 229.6 in 1940 to 223.5 in 1950. This was owing to a decrease among males from a rate of 272.8 in 1940 to 252.3 in 1950. The rate for females increased from 193.2 to 199.2.

Of greater significance, however, is the comparison by age (Table 4). Among males the average rates in 1950 exceeded those for 1940 through ages 25-29, though in decreas-



TABLE 5

*Average annual rates of first admissions among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
under 10.....	3.7	0.7	2.2	3.9	1.4	2.7	0.94	0.50	0.81
10-14 .....	17.6	11.4	14.6	9.8	5.9	7.9	1.80	1.93	1.84
15-19 .....	82.6	73.1	77.8	55.8	46.4	51.2	1.48	1.58	1.52
20-24 .....	141.9	96.9	118.3	96.7	76.6	86.4	1.47	1.27	1.37
25-29 .....	128.4	114.6	121.2	102.4	97.6	99.9	1.25	1.17	1.21
30-34 .....	105.8	118.6	112.5	114.2	104.5	109.2	0.93	1.13	1.03
35-39 .....	105.6	118.9	112.5	123.5	115.4	119.4	0.86	1.03	0.94
40-44 .....	109.1	124.2	116.8	131.1	111.7	121.4	0.83	1.11	0.96
45-49 .....	113.6	132.3	123.0	134.3	127.3	130.9	0.84	1.04	0.94
50-54 .....	127.4	135.2	131.4	154.9	141.7	148.5	0.82	0.95	0.88
55-59 .....	144.2	143.0	143.6	164.5	142.4	153.7	0.88	1.00	0.93
60-64 .....	184.6	159.9	172.3	207.1	172.4	189.4	0.89	0.93	0.91
65-69 .....	255.3	209.4	231.2	269.9	229.6	248.8	0.94	0.91	0.93
70-74 .....	386.4	363.3	373.9	361.0	310.9	334.2	1.07	1.17	1.12
75 or over....	797.8	792.8	795.0	665.7	584.4	620.0	1.20	1.36	1.28
TOTAL	121.7	124.9	123.4	115.4	105.3	110.3	1.05	1.19	1.12

ing ratios. Beyond age 30 the rates were all systematically lower in 1950. The trend was similar for females. Rates were higher in 1950 through ages 35-39, but the rates were all lower in 1950 beginning with ages 40-44. In general, the rates decreased more rapidly among females.

The trend was different for the white population, among whom the rate rose from 110.3 in 1940 to 123.4 in 1950 (Table 4). The increases occurred at the younger ages (under 35) and in old age (70 and over). Between these ages the rates decreased in amounts varying from 4% to 12%.

Among white males the rate increased during the decade by 20% at ages 10-14.

The rates continued to grow, but at a decreasing ratio, through ages 25-29. The rates decreased at succeeding ages until advanced age, when they increased by 20%. Among females the rates increased at almost all ages during the decade.

Table 6 compares the average annual rates of first admissions among Negroes and whites at corresponding ages in 1950. Negroes had higher rates throughout. At younger ages the rates were in excess by over 100%. The ratios declined through ages 45-49, but increased at older ages. Males and females showed similar trends, though in general Negro males exceed white males in higher ratios than those of females.

# Mental disease among Negroes

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It was shown that Negroes and whites had crude rates of 223.5 and 123.4 respectively, a ratio of 1.81 to 1. This comparison is distorted, however, by the fact that the general Negro population is younger than the white population of New York State. In fact, the median age of Negroes decreased between 1940 and 1950, whereas that of whites increased. It is necessary to correct for such differences, and the results are summarized in Table 7 in the form of standardized rates.

Negroes had an average annual standardized rate of 325.8 per 100,000 population during 1949-51. Males and females had

corresponding rates of 365.2 and 280.5 respectively. The male rate was in excess by 30%. Compared with 1939-41, there were significant decreases. The rate fell from 377.4 in 1940 to 325.8 in 1950, a decrease of 14%. The male rate decreased more rapidly, falling from 435.1 in 1940 to 365.2 in 1950, or by 16%. The female rate decreased from 312.6 in 1940 to 280.5 in 1950, or by 10%. In consequence, the male rate, which was in excess of the female rate by 39% in 1940 was in excess by only 30% in 1950.

The trend differed significantly for the white population. The standardized rate

TABLE 6

*Average annual rates of first admissions among Negroes and whites to all hospitals for mental disease in New York State, 1949-51, per 100,000 corresponding population*

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
under 10.....	7.9	2.1	5.0	3.7	0.7	2.2	2.14	3.00	2.27
10-14 .....	91.4	110.1	101.0	17.6	11.4	14.6	5.19	9.66	6.92
15-19 .....	246.0	212.8	227.9	82.6	73.1	77.8	2.98	2.91	2.93
20-24 .....	422.6	193.0	287.7	141.9	96.9	118.3	2.98	1.99	2.43
25-29 .....	366.4	216.3	282.1	128.4	114.6	121.2	2.85	1.89	2.33
30-34 .....	314.9	215.5	258.3	105.8	118.6	112.5	2.98	1.82	2.30
35-39 .....	259.3	237.2	246.8	105.6	118.9	112.5	2.46	1.99	2.19
40-44 .....	277.4	190.0	230.1	109.1	124.2	116.8	2.54	1.53	1.97
45-49 .....	222.3	177.3	198.7	113.6	132.3	123.0	1.96	1.34	1.62
50-54 .....	249.6	243.1	246.3	127.4	135.2	131.4	1.96	1.80	1.87
55-59 .....	324.7	242.8	282.6	144.2	143.0	143.6	2.25	1.70	1.97
60-64 .....	383.1	383.9	383.4	184.6	159.9	172.3	2.08	2.40	2.23
65-69 .....	615.7	471.3	532.6	255.3	209.4	231.2	2.41	2.25	2.30
70-74 .....	715.8	720.7	718.6	386.4	363.3	373.9	1.85	1.98	1.92
75 or over....	1,488.7	1,248.9	1,332.6	797.8	792.8	795.0	1.87	1.58	1.68
TOTAL.	252.3	199.2	223.5	121.7	124.9	123.4	2.07	1.59	1.81

rose from 147.0 in 1940 to 153.8 in 1950. The male rate varied insignificantly during the decade, but the female rate grew from 136.4 to 151.0. Thus, whereas the rate for male Negroes declined, that for whites was practically constant. Negro females showed a decline of 10% during the decade, compared with an increase of 11% among white females.

In consequence, the standardized rate for Negroes, which exceeded that of whites by almost 160% in 1940, was in excess in 1950 by only 112%. For males the rates were in the ratio of 2.35 to 1 in 1950, compared with a ratio of 2.82 to 1 in 1940. Among females the rate for Negroes remained in excess, but the ratio fell from 2.29 to 1 in 1940 to 1.86 to 1 in 1950.

The lowering of the general rate of first admissions among Negroes, in contrast to the marked increase during the preceding decade, may possibly be explained by relative improvement in the status of Negroes. This improvement may be seen in the shifting of the Negro population within New York City, which includes 80% of the

total Negro population of New York State. In 1940 there were 458,444 Negroes in New York City, of whom 298,365, or 65.1%, were in Manhattan, primarily in Harlem. In 1950 there were 747,608 Negroes in New York City, of whom 384,482, or only 51.4% were in Manhattan. The greatest relative increase occurred in the Bronx. In 1940 this borough included only 23,529 Negroes, or 5.1% of the total Negro population. By 1950 the number living in the Bronx had increased four-fold to 97,752, or 13.1% of the total. The greatest numerical increase occurred in Brooklyn, where the Negro population grew from 107,263 in 1940 to 208,478 in 1950; the percentage of the total increased from 23.4 to 27.9. The number of Negroes in Queens County grew to 51,524 in 1950, twice that of 1940, but the percentage of the total Negro population grew only from 5.7 to 6.9.

In general, these changes meant an improvement in the gross environment of Negroes. Without exaggerating the degree of such improvement, it remains certain that living conditions among Negroes

TABLE 7  
Average annual standardized \* rates of first admissions among Negroes and whites to all hospitals for mental disease in New York State, per 100,000 population, 1949-51 and 1939-41

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	1940	Ratio	1950	1940	Ratio	1950	1940
Males ....	365.2 ± 7.30	435.1 ± 9.92	0.84	155.3 ± 1.17	154.5 ± 1.18	1.01	2.35	2.82
Females ..	280.5 ± 5.73	312.6 ± 7.57	0.90	151.0 ± 1.11	136.4 ± 1.09	1.11	1.86	2.29
TOTAL	325.8 ± 4.59	377.4 ± 6.19	0.86	153.8 ± 0.81	147.0 ± 0.81	1.04	2.12	2.57

\* Population of New York State aged 15 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.



# Mental disease among Negroes

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TABLE 8

*Negro first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, classified according to age*

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
10-14 .....	3	1	4	1.0	0.6	0.8	3.4	1.1	2.2
15-19 .....	-	-	-	-	-	-	-	-	-
20-24 .....	4	5	9	1.3	3.1	1.9	3.8	3.4	3.6
25-29 .....	16	14	30	5.1	8.6	6.3	11.9	8.1	9.7
30-34 .....	19	19	38	6.1	11.7	8.0	16.0	12.1	13.7
35-39 .....	45	32	77	14.4	19.8	16.2	38.4	21.1	28.6
40-44 .....	63	25	88	20.1	15.4	18.5	61.5	20.7	39.4
45-49 .....	37	13	50	11.8	8.0	10.5	41.1	13.1	26.4
50-54 .....	45	18	63	14.4	11.1	13.3	64.5	25.0	44.4
55-59 .....	40	11	51	12.8	6.8	10.7	89.6	23.2	55.4
60-64 .....	15	5	20	4.8	3.1	4.2	50.4	14.1	30.7
65-69 .....	17	8	25	5.4	4.9	5.3	78.1	27.1	48.8
70-74 .....	5	5	10	1.6	3.1	2.1	41.6	30.0	34.9
75-84 .....	3	4	7	1.0	2.5	1.5	38.6	24.7	31.8
85 or over....	1	1	2	0.3	0.6	0.4	66.7	33.0	44.1
Unascertained	-	1	1	-	0.6	0.2	-	-	-
TOTAL	313	162	475	100.0	100.0	100.0	24.8	10.8	17.2

in Bronx, Kings and Queens counties are superior to those in the much older Negro centers in the heart of Harlem.

A further improvement in the status of Negroes is seen in education. In 1940 the median number of school years completed by Negroes aged 25 years and over was 7.8. By 1950 this had increased to 9.6. In 1940 3.7% had had no education and 65.9% had had some degree of elementary education. In 1950 the corresponding percentages had decreased to 3.0 and 51.5 respectively. The percentage with some degree of high school education increased from 23.2 in 1940 to 33.3 in 1950. The corresponding percentages for those with some

degree of college education were 4.8 in 1940 and 6.7 in 1950.<sup>3</sup>

Still further improvement is shown by the fact that only 12% of the non-white males in the labor force in New York City in 1950 were unemployed, compared with 30% in 1940. For non-white females the corresponding percentages were 8.5 and 30 respectively.<sup>4</sup>

<sup>3</sup> These data are derived from the following reports issued by the U. S. Bureau of the Census:

*Population, 1940. Second Series. Characteristics of Population. New York, 1942. Page 25.*

*Detailed Characteristics. New York, 1950. Bulletin P-C 32. Page 233.*

<sup>4</sup> *Ibid.*

TABLE 9

*Average annual rates of first admissions with general paresis among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
15-19 .....	-	-	-	4.9	2.8	3.8	-	-	-
20-24 .....	3.8	3.4	3.6	3.4	4.3	3.9	1.12	0.79	0.92
25-29 .....	11.9	8.1	9.7	27.9	13.5	19.7	0.43	0.60	0.49
30-34 .....	16.0	12.1	13.7	78.7	20.1	45.7	0.20	0.60	0.30
35-39 .....	38.4	21.1	28.6	91.8	23.3	54.7	0.42	0.91	0.52
40-44 .....	61.5	20.7	39.4	78.0	33.4	55.4	0.79	0.62	0.71
45-49 .....	41.1	13.1	26.4	134.0	35.1	84.1	0.31	0.37	0.31
50-54 .....	64.5	25.0	44.4	143.1	26.7	83.4	0.45	0.94	0.53
55-59 .....	89.6	23.2	55.4	101.1	36.3	67.4	0.89	0.64	0.82
60-64 .....	50.4	14.1	30.7	95.1	65.1	79.4	0.53	0.22	0.39
65-69 .....	78.1	27.1	48.8	119.7	21.0	63.6	0.65	1.29	0.77
70 or over....	42.3	29.4	34.4	85.4	13.4	41.2	0.50	2.19	0.83
TOTAL	24.8	10.8	17.2	54.5	16.4	33.9	0.46	0.66	0.51

Health, including mental health, is related to economic status. The amount of illness in a population decreases with a rise in economic level. It may therefore be inferred that the relative improvement in mental health among Negroes in New York State, as measured by first admissions to hospitals for mental disease, is associated with a rise in their economic level and with other environmental improvements.

#### GENERAL PARESIS

The widespread prevalence of syphilis among Negroes makes it a problem of great significance to public health. In the field of mental health it manifests itself by an excessive prevalence of general paresis and

other disorders of syphilitic origin. Previous studies have shown that the greatest excess of rates of first admissions by Negroes over whites occurs in connection with general paresis. The data for 1950 confirm this conclusion.

There were 475 Negro first admissions with general paresis during the 3-year period 1949-51, or an average annual rate of 17.2 per 100,000 Negroes. The rate rose, in general, with advancing age to a maximum of 55.4 at ages 55-59 (Table 8). The rate increased among males to a maximum of 89.6 at ages 55-59, with an average rate of 24.8 for all male Negroes. Among females the rates rose to a maximum of 25.0 at ages 50-54, with an average rate of 10.8. The male rate exceeded that for

females in the ratio of 2.3 to 1. The relative excess of the males grew from 12% at ages 20-24 to almost 300% at ages 55-59.

Between 1930 and 1940 the average annual rate of first admissions with general paresis grew among Negroes from 25.0 to 33.9. Between 1940 and 1950, however, there was a significant decline to 17.2, a decrease of 49%. The decrease occurred at all ages. In general, though the rates for males exceeded those for females, the former declined more rapidly during the decade. Between ages 25-55 the rates were reduced by approximately 50% to 60%. The rate of decrease was less at older ages. Among females the rates fell during the decade by approximately 40% up to age 45, declined by smaller amounts through age 64, but increased at ages 65 and over.

The white population had an average annual rate of 1.5 per 100,000 population. Males and females had rates of 2.2 and 0.8 respectively. In 1940 the white population had a rate of 5.8, indicating a decrease of 74% during the following decade, compared with a decrease of 49% among Negroes. Thus, though both whites and Negroes had declining rates of first admissions with general paresis, the decrease was relatively greater among whites, so that the relative excess of Negroes over whites increased during the decade. The relative excess was greatest at the youngest ages (Table 11).

The Negro population is relatively younger than the white population, a larger proportion falling within the age range associated with general paresis. This

TABLE 10

*Average annual rates of first admissions with general paresis among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
15-19 .....	-	0.6	0.3	0.4	0.8	0.6	-	0.75	0.50
20-24 .....	0.1	0.1	0.1	0.4	0.5	0.4	0.25	0.20	0.25
25-29 .....	0.3	0.1	0.2	2.1	1.7	1.9	0.14	0.06	0.11
30-34 .....	0.4	0.4	0.4	8.6	3.7	6.1	0.04	0.11	0.07
35-39 .....	1.3	1.0	1.2	14.7	5.6	10.2	0.09	0.18	0.12
40-44 .....	3.6	1.5	2.5	20.4	5.6	13.1	0.18	0.27	0.19
45-49 .....	4.5	1.9	3.2	20.2	3.3	12.9	0.22	0.58	0.24
50-54 .....	5.3	1.7	3.4	21.4	5.4	13.7	0.24	0.31	0.24
55-59 .....	6.9	2.3	4.6	17.8	4.0	11.5	0.39	0.58	0.40
60-64 .....	6.4	1.5	4.0	14.8	4.3	9.4	0.43	0.34	0.43
65-69 .....	4.2	1.4	2.8	13.2	3.1	7.9	0.32	0.45	0.35
70 or over....	4.0	1.0	2.3	6.6	1.9	4.0	0.61	0.53	0.58
TOTAL	2.2	0.8	1.5	8.8	2.8	5.8	0.25	0.29	0.26



TABLE 11

*Average annual rates of first admissions with general paresis among Negroes and whites to all hospitals for mental disease in New York State, 1949-51, per 100,000 corresponding population*

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
15-19 .....	-	-	-	-	0.6	0.3	-	-	-
20-24 .....	3.8	3.4	3.6	0.1	0.1	0.1	38.00	34.00	36.00
25-29 .....	11.9	8.1	9.7	0.3	0.1	0.2	39.67	81.00	48.50
30-34 .....	16.0	12.1	13.7	0.4	0.4	0.4	40.00	30.25	34.25
35-39 .....	38.4	21.1	28.6	1.3	1.0	1.2	29.54	21.00	23.88
40-44 .....	61.5	20.7	39.4	3.6	1.5	2.5	17.08	13.80	15.76
45-49 .....	41.1	13.1	26.4	4.5	1.9	3.2	9.13	6.89	8.25
50-54 .....	64.5	25.0	44.4	5.3	1.7	3.4	12.17	14.71	13.06
55-59 .....	89.6	23.2	55.4	6.9	2.3	4.6	12.99	10.09	12.04
60-64 .....	50.4	14.1	30.7	6.4	1.5	4.0	7.88	9.40	7.68
65-69 .....	78.1	27.1	48.8	4.2	1.4	2.8	18.60	19.36	17.43
70 or over....	42.3	29.4	34.4	4.0	1.0	2.3	10.58	29.40	14.96
TOTAL	24.8	10.8	17.2	2.2	0.8	1.5	11.27	13.50	11.47

TABLE 12

*Average annual standardized \* rates of first admissions with general paresis among Negroes and whites to all hospitals for mental disease in New York State, per 100,000 population, 1949-51 and 1939-41*

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	1940	Ratio	1950	1940	Ratio	1950	1940
Males .....	38.6 ± 2.36	77.6 ± 4.20	0.50	2.8 ± 0.16	11.9 ± 0.33	0.24	13.79	6.52
Females ....	14.9 ± 1.33	23.4 ± 2.08	0.64	1.1 ± 0.10	3.4 ± 0.17	0.32	13.54	6.88
TOTAL	26.7 ± 1.32	49.4 ± 2.24	0.54	1.9 ± 0.09	7.4 ± 0.18	0.26	14.05	6.68

\* Population of New York State aged 15 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

# Mental disease among Negroes

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influences the relative incidence of general paresis among the races. It is therefore necessary to standardize the rates. These are shown for Negroes and whites for 1940 and 1950 in Table 12.

The standardized rate for Negroes fell from 49.4 in 1940 to 26.7 in 1950, a decrease of 46%. The decrease was more marked among males, the rate falling from 77.6 to 38.6, a decrease of 50%. The standardized rate fell among female Negroes from 23.4 to 14.9, or by 36%. The rate for males was in excess in 1940 in the ratio of 3.32 to 1. In 1950 the ratio was reduced to 2.59 to 1.

The standardized rate declined among the white population from 7.4 in 1940 to 1.9 in 1950, a reduction of 74% compared with a reduction of 46% among Negroes.

The rate for white males decreased from 11.9 to 2.8, or by 76%. The rate decreased among white females from 3.4 to 1.1, or by 68%. Thus, as with Negroes there was a relatively greater decrease among males than females. In 1940 the rates for males and females were in the ratio of 3.50 to 1. In 1950 they were in the ratio of 2.54 to 1.

Thus, though the standardized rates of first admissions with general paresis decreased among both whites and Negroes, the relative excess of the Negro rate increased during the decade. In 1940 the Negro rate was in excess in the ratio of 6.68 to 1. This grew to 14.05 to 1 in 1950. We may conclude, therefore, that Negroes are benefiting from the application of methods to control the spread of syphilis, but that such measures have thus far been

TABLE 13

*Negro first admissions with alcoholic psychoses to all hospitals for mental disease in New York State, 1949-51, classified according to age*

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
15-19 .....	-	1	1	-	0.6	0.2	-	1.0	0.6
20-24 .....	15	13	28	4.1	7.7	5.2	14.4	8.7	11.1
25-29 .....	39	28	67	10.7	16.6	12.5	28.9	16.2	21.8
30-34 .....	52	34	86	14.2	20.1	16.1	43.7	21.6	31.1
35-39 .....	67	30	97	18.4	17.8	18.2	57.2	19.8	36.1
40-44 .....	72	27	99	19.7	16.0	18.5	70.3	22.4	44.4
45-49 .....	50	13	63	13.7	7.7	11.8	55.6	13.1	33.3
50-54 .....	38	11	49	10.4	6.5	9.2	54.5	15.3	34.6
55-59 .....	16	7	23	4.4	4.1	4.3	35.8	14.8	25.0
60-64 .....	10	4	14	2.7	2.4	2.6	33.6	11.3	21.4
65-69 .....	6	-	6	1.6	-	1.1	27.6	-	11.7
Unascertained	-	1	1	-	0.6	0.2	-	-	-
TOTAL	365	169	534	100.0	100.0	100.0	28.9	11.3	19.4

TABLE 14

*Average annual rates of first admissions with alcoholic psychoses among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
15-19 .....	-	1.0	0.6	1.6	-	0.8	-	-	0.75
20-24 .....	14.4	8.7	11.1	18.6	7.4	11.8	0.77	1.18	0.94
25-29 .....	28.9	16.2	21.8	43.9	15.3	27.3	0.67	1.06	0.80
30-34 .....	43.7	21.6	31.1	72.6	22.0	44.1	0.60	0.98	0.71
35-39 .....	57.2	19.8	36.1	59.7	23.3	39.9	0.96	0.84	0.90
40-44 .....	70.3	22.4	44.4	89.9	20.6	58.1	0.78	1.09	0.76
45-49 .....	55.6	15.1	33.3	91.1	19.3	54.9	0.61	0.68	0.61
50-54 .....	54.5	15.3	34.6	61.3	14.6	37.4	0.89	1.04	0.93
55-59 .....	35.8	14.8	25.0	58.3	14.4	35.6	0.61	1.03	0.70
60-64 .....	33.6	11.3	21.4	53.5	5.4	28.4	0.63	2.09	0.75
65-69 .....	27.6	-	11.7	46.0	7.0	23.8	0.60	-	0.49
70 or over....	-	-	-	32.0	-	12.4	-	-	-
TOTAL	28.9	11.3	19.4	42.4	11.9	25.9	0.68	0.95	0.75

more effective among the white population. The goal must be the more intensive application of preventive measures among Negroes, to reduce the disparity in comparison with whites.

#### ALCOHOLIC PSYCHOSES

Negroes have shown a great relative excess over whites in the frequency of alcoholic psychoses, the degree of excess being second only to that for general paresis. The data for 1950 repeat this comparison.

There were 534 Negro first admissions with alcoholic psychoses to all hospitals for mental disease in New York State during 1949-51 inclusive, or an average annual rate of 19.4 per 100,000 Negroes. The cor-

responding rate in 1940 was 25.9. This is a substantial reduction, and is in marked contrast to a rise from 15.1 in 1930 to 25.9 in 1940. The decrease occurred almost entirely among males; their rate dropped from 42.4 in 1940 to 28.9 in 1950. The female rates were 11.9 in 1940 and 11.3 in 1950.

The average annual rate increased with advancing age to a maximum of 44.4 at ages 40-44, and declined at higher ages. Among males the rate reached a maximum of 70.3 at ages 40-44. Females reached a maximum rate of 22.4 at the same age.

At every age Negro males had a lower rate in 1950 than in 1940 (Table 14). The reductions varied from only 4% at ages 35-39 and 11% at ages 50-54 to 40% at



the other ages. The maximum rate in 1940 was 91.1 at ages 45-49. The maximum in 1950 was only 70.3 at ages 40-44. Among Negro females, however, there was only one significant reduction, namely, from 19.3 in 1940 at ages 45-49 to 13.1 in 1950. On the other hand, the rate increased at ages 60-64 from 5.4 to 11.3. The female rates in 1950 exceeded those for 1940 at most ages, in contrast to males.

The white population of New York State had lower rates of first admissions with alcoholic psychoses than Negroes. The crude rates were 6.5 and 19.4 for whites and Negroes respectively. At ages 20-54 white males showed substantial reductions in rates between 1940 and 1950, though the relative reductions were not so great as those for Negro males. After age 55 the rates in-

creased among whites, whereas they decreased among Negroes. As with Negro females the rates increased among white females between 1940 and 1950 in most age groups, resulting in an increase of the general white female rate during the decade.

Table 16 compares the average annual rates among Negroes and whites according to age. At every age the rate for Negroes was in significant excess. The degree of excess declined, however, with advancing age. The ratio of the corresponding rates fell steadily from 27.75 to 1 at ages 20-24 to a minimum of 1.04 to 1 at ages 65-69. The degree of excess varied between the sexes. Thus, rates for Negro males exceeded those for whites in ratios that declined from 14.40 to 1 at ages 20-24 to 1.40 to 1 at ages 65-69. With minor fluctuations, Negro

TABLE 15

*Average annual rates of first admissions with alcoholic psychoses among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
15-19 .....	0.2	0.2	0.2	-	-	-	-	-	-
20-24 .....	1.0	-	0.4	0.8	0.1	0.4	0.13	-	1.00
25-29 .....	3.2	1.1	2.1	4.9	1.4	3.1	0.65	0.79	0.68
30-34 .....	7.5	1.7	4.4	12.6	3.2	7.8	0.60	0.53	0.56
35-39 .....	12.0	4.6	8.2	22.1	3.7	12.9	0.54	1.24	0.64
40-44 .....	20.4	7.6	14.0	24.3	4.2	14.3	0.84	1.81	0.98
45-49 .....	26.2	7.0	16.4	26.9	4.4	15.8	0.97	1.59	1.04
50-54 .....	25.8	4.5	15.1	27.9	5.6	17.1	0.92	0.80	0.88
55-59 .....	25.4	5.7	15.6	22.7	4.8	14.0	1.12	1.19	1.11
60-64 .....	22.1	4.7	13.4	21.1	4.9	12.8	1.04	0.96	1.04
65-69 .....	19.7	3.4	11.2	16.8	2.3	9.2	1.17	1.48	1.22
70 or over....	5.4	0.9	2.9	4.4	1.3	2.7	1.23	0.69	1.07
TOTAL	10.5	2.7	6.5	11.7	2.2	7.0	0.90	1.23	0.93

females had higher rates than white females in ratios exceeding those for males at corresponding ages.

As with general paresis the Negro population is concentrated more heavily than whites at those ages which constitute the period of highest risk for alcoholic psychoses. Therefore, it is desirable to reduce the comparisons to a common standard (Table 17).

On this basis, the Negro rate was reduced from 36.0 per 100,000 in 1940 to 27.0 in 1950, a reduction of 25%. The reduction occurred principally among males, the rate falling from 58.8 in 1940 to 40.8 in 1950, a reduction of 30%. Among Negro females, however, the rate was reduced by only 3%, from 14.9 in 1940 to 14.4 in 1950. Thus, the ratio of the rates among Negroes was re-

duced from 3.94 to 1 in 1940 to 2.83 to 1 in 1950, implying a relative increase among Negro females when contrasted with males.

The rate for whites decreased from 9.8 in 1940 to 9.0 in 1950, a decrease of only 8%, compared with 25% for Negroes. The decrease among whites was limited to males, the rate having declined from 16.9 in 1940 to 14.8 in 1950. Among white females, however, the rate increased from 3.3 to 3.8. Whereas the male rate exceeded that for females in the ratio of 5.12 to 1 in 1940, the ratio was only 3.89 to 1 in 1950. Thus, rates for males are in substantial excess over those for females, but the disparity was reduced significantly in 1950.

Rates for the white population were at a lower level. In 1950 the standardized rates were 27.0 for Negroes, compared with

TABLE 16  
*Average annual rates of first admissions with alcoholic psychoses among Negroes and whites to all hospitals for mental disease in New York State, 1949-51, per 100,000 corresponding population*

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
15-19 .....	-	1.0	0.6	0.2	0.2	0.2	-	5.00	3.00
20-24 .....	14.4	8.7	11.1	1.0	-	0.4	14.40	-	27.75
25-29 .....	28.9	16.2	21.8	3.2	1.1	2.1	9.03	14.73	10.88
30-34 .....	43.7	21.6	31.1	7.5	1.7	4.4	5.83	12.71	7.07
35-39 .....	57.2	19.8	36.1	12.0	4.6	8.2	4.77	4.30	4.40
40-44 .....	70.3	22.4	44.4	20.4	7.6	14.0	3.44	2.94	3.17
45-49 .....	55.6	13.1	33.3	26.2	7.0	16.4	2.12	1.87	2.03
50-54 .....	54.3	15.3	34.6	25.8	4.5	15.1	2.11	3.40	2.29
55-59 .....	35.8	14.8	25.0	25.4	5.7	15.6	1.41	2.60	1.60
60-64 .....	33.6	11.3	21.4	22.1	4.7	13.4	1.52	2.40	1.60
65-69 .....	27.6	-	11.7	19.7	3.4	11.2	1.40	-	1.04
70 or over....	-	-	-	5.4	0.9	2.9	-	-	-
TOTAL	28.9	11.3	19.4	10.5	2.7	6.5	2.75	4.19	2.98

# Mental disease among Negroes

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TABLE 17

*Average annual standardized \* rates of first admissions with alcoholic psychoses among Negroes and whites to all hospitals for mental disease in New York State, per 100,000 population, 1949-51 and 1939-41*

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	1940	Ratio	1950	1940	Ratio	1950	1940
Males .....	40.8 ± 2.55	58.8 ± 3.86	0.69	14.8 ± 0.36	16.9 ± 0.41	0.88	2.76	3.48
Females ....	14.4 ± 1.36	14.9 ± 1.74	0.97	3.8 ± 0.18	3.3 ± 0.18	1.15	3.79	4.52
TOTAL ....	27.0 ± 1.38	36.0 ± 2.02	0.75	9.0 ± 0.20	9.8 ± 0.22	0.92	3.00	3.67

\* Population of New York State aged 20 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

9.0 for whites, a ratio of 3 to 1. For males the rates were 40.8 and 14.8 respectively, a ratio of 2.76 to 1. Among females the rate for Negroes was in excess in the ratio of 3.79 to 1.

In 1940 the Negro male rate exceeded that of whites in the ratio of 3.48 to 1. This was reduced to a ratio of 2.76 to 1 in 1950. In 1940 the Negro female rate was in excess of that of white females in the ratio of 4.52 to 1. In 1950 the ratio declined to 3.79 to 1.

It is unlikely that selective factors, such as migration, were responsible for the change in the level of alcoholic psychoses among Negroes. The migratory element, defined as being born outside New York State, included the same proportion of Negroes (64%) in both 1940 and 1950. It is probable, therefore, that the same social factors which reduced the rate of alcoholic psychoses among whites also affected the Negro population similarly.

## PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS

Psychoses with cerebral arteriosclerosis are related directly to the aging of the popu-

lation. As those of advanced age (65 or over) increase in number, the number of first admissions with such psychoses may be expected to increase. The number of Negroes in New York State aged 65 years or over increased from 16,600 in 1940 to 35,495 in 1950. This age group included 2.9% of the total Negro population in 1940 and 3.9% in 1950. It is therefore important to consider the trend of psychoses with cerebral arteriosclerosis.

There were 781 such first admissions during the three years 1949-51, with an average annual rate of 28.3 per 100,000 Negroes. Males and females had rates of 28.6 and 28.0 respectively. These represent decreases compared with the corresponding rates for 1940 (Table 19).

The average annual rate increased with advancing age to a maximum of 878.4 at ages 80-84. The maximum for males was 1,068.4; that for females was 627.1. Generally, rates for males exceeded those for females at corresponding ages.

Rates for whites were lower than those for Negroes. White males had a rate of 25.2; females had a rate of 22.6. There was



an average of 23.9 for both sexes. The rates for males rose to a maximum of 500.9 at ages 85 and over. They rose among females to 321.8 at ages 80-84 and 308.4 at ages 85 and over. At all corresponding ages males had higher rates than females.

Table 19 shows comparisons of rates among Negroes in 1940 and 1950. At every age there was a reduction in rates during the decade. The differences between the two sets of rates decreased with advancing age. With minor exceptions, males and females both showed the same trend.

Rates of first admissions with psychoses with cerebral arteriosclerosis increased among whites between 1940 and 1950. This resulted from increases among those of advanced age (70 or over). At all other ages the annual rates were less in 1950 than in

1940, though the differences decreased with advancing age.

Table 21 compares the annual rates for Negroes and whites in 1950. The total rate for Negroes was in excess by 18%. Rates for Negroes were in excess at every age. The degree of excess declined, however, from a ratio of 9.64 to 1 at ages 45-49 to 1.85 to 1 at ages 75 or over. The trend was similar for each sex. In general, however, rates for Negro females exceeded those for white females in higher ratios than occurred among males.

It is always necessary to consider the differential age distributions of the two racial groups. The white population includes a higher proportion at advanced ages. Rates on a comparable base are therefore shown in Table 22.

TABLE 18

*Negro first admissions with psychoses with cerebral arteriosclerosis to all hospitals for mental disease in New York State, 1949-51, classified according to age*

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
35-39 .....	-	1	1	-	0.2	0.1	-	0.7	0.4
40-44 .....	-	3	3	-	0.7	0.4	-	2.4	1.3
45-49 .....	9	11	20	2.5	2.6	2.6	10.0	11.1	10.6
50-54 .....	24	29	53	6.6	6.9	6.8	34.4	40.3	37.4
55-59 .....	47	42	89	13.0	10.0	11.4	105.3	88.7	96.7
60-64 .....	56	80	136	15.4	19.1	17.4	188.2	225.8	208.6
65-69 .....	87	93	180	24.0	22.2	23.0	399.7	315.4	351.2
70-74 .....	64	73	137	17.7	17.4	17.5	532.7	438.4	477.9
75-79 .....	41	36	77	11.3	8.6	9.9	735.1	351.9	491.7
80-84 .....	25	31	56	6.9	7.4	7.2	1068.4	768.3	878.4
85 or over....	9	19	28	2.4	4.5	3.6	600.0	627.1	618.1
Unascertained	-	1	1	-	0.2	0.1	-	-	-
TOTAL	362	419	781	100.0	100.0	100.0	28.6	28.0	28.3

# Mental disease among Negroes

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TABLE 19

*Average annual rates of first admissions with psychoses with cerebral arteriosclerosis among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
35-39 .....	-	0.7	0.4	-	3.9	2.1	-	0.18	0.19
40-44 .....	-	2.4	1.3	6.6	14.2	10.4	-	0.36	0.13
45-49 .....	10.0	11.1	10.6	19.7	35.1	27.4	0.51	0.32	0.39
50-54 .....	34.4	40.3	37.4	112.5	87.5	99.7	0.31	0.46	0.38
55-59 .....	105.3	88.7	96.7	194.4	183.2	189.1	0.54	0.48	0.51
60-64 .....	188.2	225.8	208.6	315.1	271.4	292.2	0.60	0.83	0.71
65-69 .....	399.7	315.4	351.2	469.4	489.2	480.7	0.85	0.64	0.73
70-74 .....	532.7	438.4	477.9	622.9	420.6	503.6	0.86	1.04	0.94
75 or over....	809.1	497.3	606.1	760.9	795.0	782.8	1.06	0.63	0.77
TOTAL	28.6	28.0	28.3	35.7	36.0	35.8	0.80	0.78	0.79

TABLE 20

*Average annual rates of first admissions with psychoses with cerebral arteriosclerosis among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
35-39 .....	-	-	-	-	0.4	0.2	-	-	-
40-44 .....	0.3	0.6	0.4	0.9	0.6	0.8	0.33	1.00	0.50
45-49 .....	0.8	1.4	1.1	3.0	4.1	3.5	0.27	0.34	0.31
50-54 .....	8.1	5.4	6.8	20.1	14.7	17.5	0.40	0.37	0.39
55-59 .....	24.3	22.6	23.4	49.4	40.3	45.0	0.49	0.56	0.52
60-64 .....	74.7	64.4	69.6	103.5	85.2	94.1	0.72	0.76	0.74
65-69 .....	118.9	115.6	131.4	168.0	125.5	145.7	0.89	0.92	0.90
70-74 .....	235.6	184.0	206.8	211.6	154.9	181.7	1.10	1.19	1.14
75 or over....	379.5	288.4	327.1	231.1	190.8	230.3	1.35	1.51	1.42
TOTAL	25.2	22.6	23.9	22.0	18.2	20.0	1.14	1.24	1.20

TABLE 21

*Average annual rates of first admissions with psychoses with cerebral arteriosclerosis among Negroes and whites to all hospitals for mental disease in New York State, 1949-51, per 100,000 corresponding population*

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
35-39 .....	-	0.7	0.4	-	-	-	-	-	-
40-44 .....	-	2.4	1.3	0.3	0.6	0.4	-	4.00	3.25
45-49 .....	10.0	11.1	10.6	0.8	1.4	1.1	12.50	7.93	9.64
50-54 .....	34.4	40.3	37.4	8.1	5.4	6.8	4.24	7.46	5.50
55-59 .....	105.3	88.7	96.7	24.3	22.6	23.4	4.33	3.92	4.13
60-64 .....	188.2	225.8	208.6	74.7	64.4	69.6	2.52	3.51	3.00
65-69 .....	399.7	315.4	351.2	148.9	115.6	131.4	2.68	2.73	2.67
70-74 .....	532.7	438.4	477.9	233.6	184.0	206.8	2.28	2.38	2.31
75 or over....	809.1	497.3	606.1	379.5	288.4	327.1	2.13	1.72	1.85
TOTAL	28.6	28.0	28.3	25.2	22.6	23.9	1.13	1.24	1.18

The standardized rate for Negroes was reduced from 253.2 in 1940 to 180.7 in 1950, a reduction of 30%. The male rate was reduced by 29%, from 254.8 in 1940 to 191.4 in 1950. The female rate was reduced

by a third, from 235.0 in 1940 to 158.4 in 1950. The male rates exceeded those for females in both years, though the differences are not statistically significant.

Rates for the white population decreased

TABLE 22

*Average annual standardized \* rates of first admissions with psychoses with cerebral arteriosclerosis among Negroes and whites, to all hospitals for mental disease in New York State, per 100,000 population, 1949-51 and 1939-41*

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	1940	Ratio	1950	1940	Ratio	1950	1940
Males ....	191.4 ± 9.71	254.8 ± 14.78	0.75	75.4 ± 1.24	81.0 ± 1.39	0.93	2.54	3.14
Females ..	158.4 ± 8.24	235.0 ± 13.52	0.67	59.9 ± 1.08	61.0 ± 1.21	0.98	2.64	3.85
TOTAL ..	180.7 ± 6.43	253.2 ± 10.16	0.71	71.1 ± 0.84	73.0 ± 0.93	0.97	2.54	3.47

\* Population of New York State aged 45 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.



# Mental disease among Negroes

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TABLE 23

*Negro first admissions with senile psychoses to all hospitals for mental disease in New York State, 1949-51, classified according to age*

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
50-54 .....	1	1	2	1.0	0.5	0.7	1.4	1.4	1.4
55-59 .....	-	3	3	-	1.4	1.0	-	6.3	3.3
60-64 .....	8	15	23	8.1	7.4	7.6	26.9	42.3	35.3
65-69 .....	18	23	41	18.2	11.3	13.6	82.7	78.0	80.0
70-74 .....	13	39	52	13.1	19.2	17.2	108.2	236.4	181.4
75-79 .....	24	45	69	24.2	22.2	22.8	442.0	439.9	440.6
80-84 .....	16	51	67	16.2	25.1	22.2	683.8	1263.9	1051.0
85 or over....	19	26	45	19.2	12.8	14.9	1266.7	858.1	993.4
TOTAL	99	203	302	100.0	100.0	100.0	7.8	13.6	10.9

between 1940 and 1950, though the decreases were small and not significant.

The rate for Negroes exceeded that for whites in 1950. They were in the ratio of 2.54 to 1. Because of the more rapid decrease of the Negro rate, however, the excess was reduced between 1940 and 1950. In the former year the rate for Negroes was in excess in the ratio of 3.47 to 1.

Because of their more difficult lives it is probable that Negroes do not reach advanced age in as good physical condition as whites. Such influences would tend to raise the rates of first admissions with cerebral arteriosclerosis among Negroes above the level of those for whites.

## SENILE PSYCHOSES

There were 302 Negro first admissions with senile psychoses during 1949-51. The rate per 100,000 population was 10.9. Males and females had rates of 7.8 and 13.6 respectively. Compared with the previous decade,

there was a small but not significant decrease among males from a rate of 9.6 to 7.8. Females, on the contrary, increased their rate from 12.2 to 13.6. Males showed decreased rates at every age level between 1940 and 1950. There were similar decreases among females at all ages except 55-59.

Crude rates of first admissions with senile psychoses were higher among the white population. The average annual rate was 17.2 per 100,000. Males and females had rates of 13.2 and 21.0 respectively. The larger white population provides more stable rates, and these show a progressive increase with age to a maximum of 878.6 at 85 years and over. At each age level females had higher rates than males.

Unlike Negroes, the white population had higher rates of first admissions with senile psychoses in 1950 than in 1940. The rates rose from 11.8 to 17.2. Rates for males increased from 9.8 to 13.2. Among females

TABLE 24

*Average annual rates of first admissions with senile psychoses among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
45-49 .....	-	-	-	1.8	-	0.9	-	-	-
50-54 .....	1.4	1.4	1.4	-	7.3	3.7	-	0.19	0.38
55-59 .....	-	6.3	3.3	-	3.6	1.9	-	1.75	1.74
60-64 .....	26.9	42.3	35.3	53.5	65.1	59.6	0.50	0.65	0.59
65-69 .....	82.7	78.0	80.0	156.4	104.8	127.1	0.53	0.74	0.63
70-74 .....	108.2	236.4	181.4	320.9	276.0	294.4	0.34	0.86	0.62
75 or over....	636.4	705.4	681.3	760.9	836.1	809.1	0.84	0.84	0.84
TOTAL	7.8	13.6	10.9	9.6	12.2	11.0	0.81	1.11	0.99

they increased from 13.8 to 21.0. The increased rates were limited, however, to those of advanced age. The rate rose by 10% among those aged 70-74 and by 22% among those aged 75 or over.

Table 26 compares rates of first admissions among Negroes and whites in 1950. It will be noted that the total crude rates were lower for Negroes. This is an artifact, however, due to the differing age structures of the two populations. A large proportion of the Negro population is aged less than 45 years. At corresponding ages over 45 the rates for Negroes were in significant excess. At ages 50-54, for example, the rate for Negroes was in excess in the ratio of 7.0 to 1. Rates for Negroes were in excess at all higher ages, but in decreasing ratios. Among those aged 75 and over the rate for Negroes was in excess in the ratio of 1.5 to 1.

Because of age differentials in the two populations it is necessary to standardize the rates. The standardized rate for Negroes

fell from 109.0 in 1940 to 80.8 in 1950, a decrease of 26%. The standardized rate declined among males from 99.6 to 64.3 and among females from 99.5 to 80.8. The rate for females in 1950 was in excess of the male rate in the ratio of 1.26 to 1. Though the standardized rates for Negroes decreased in 1950, those for whites increased. The rate for whites rose from 45.2 in 1940 to 50.9 in 1950. The rate for males rose slightly from 37.4 to 39.3 but that for females rose significantly from 43.9 to 50.9. The relative excess of the female rate increased in 1950.

Despite the decrease among Negroes in 1950 their standardized rates remained in substantial excess over those for whites. In 1950 the rate for Negroes was in excess by 50%. In 1940, however, the rate for Negroes had been in excess by 140%. The future trend is not clear. The proportion of the aged is certain to rise, thereby increasing the number exposed to the risk of a senile psychosis. On the other hand, im-

# Mental disease among Negroes

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TABLE 25

*Average annual rates of first admissions with senile psychoses among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
40-44 .....	-	-	-	0.1	-	*	-	-	-
45-49 .....	-	-	-	-	0.2	0.1	-	-	-
50-54 .....	0.1	0.3	0.2	0.6	1.3	0.9	0.17	0.23	0.22
55-59 .....	0.4	1.2	0.8	1.7	3.0	2.4	0.24	0.40	0.33
60-64 .....	8.3	11.1	9.7	11.2	17.6	14.4	0.74	0.63	0.67
65-69 .....	32.3	42.9	37.9	30.8	52.4	42.1	1.04	0.82	0.90
70-74 .....	108.1	152.5	132.1	110.6	127.4	119.6	0.98	1.20	1.10
75 or over....	394.0	493.7	451.3	356.0	379.1	369.0	1.11	1.30	1.22
TOTAL	19.2	21.0	17.2	9.8	13.8	11.8	1.34	1.52	1.46

\* Less than 0.05.

TABLE 26

*Average annual rates of first admissions with senile psychoses among Negroes and whites to all hospitals for mental disease in New York State, 1949-51, per 100,000 corresponding population*

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
45-49 .....	-	-	-	-	-	-	-	-	-
50-54 .....	1.4	1.4	1.4	0.1	0.3	0.2	14.00	4.67	7.00
55-59 .....	-	6.3	3.3	0.4	1.2	0.8	-	5.25	4.13
60-64 .....	26.9	42.3	35.3	8.3	11.1	9.7	3.24	3.81	3.64
65-69 .....	82.7	78.0	80.0	32.3	42.9	37.9	2.56	1.82	2.11
70-74 .....	108.2	236.4	181.4	108.1	152.5	132.1	1.00	1.55	1.37
75 or over....	636.4	705.4	681.3	394.0	493.7	451.3	1.62	1.43	1.51
TOTAL	7.8	13.6	10.9	13.2	21.0	17.2	0.59	0.64	0.63



TABLE 27

*Average annual standardized \* rates of first admissions with senile psychoses among Negroes and whites, to all hospitals for mental disease in New York State, per 100,000 population, 1949-51 and 1939-41*

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	1940	Ratio	1950	1940	Ratio	1950	1940
Males .....	64.3 ± 5.63	99.6 ± 9.25	0.64	39.3 ± 0.90	37.4 ± 0.95	1.05	1.64	2.66
Females ....	80.8 ± 5.89	99.5 ± 8.82	0.81	50.9 ± 0.99	43.9 ± 1.02	1.16	1.59	2.27
TOTAL	80.4 ± 4.29	109.0 ± 6.67	0.74	50.9 ± 0.71	45.2 ± 0.74	1.13	1.59	2.41

\* Population of New York State aged 45 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

provement in physical health, consequent upon a rise in the standard of living, may keep down the level of such psychoses.

INVOLUTIONAL PSYCHOSES

There were 122 Negro first admissions with involutional psychoses during 1949-51, or an average annual rate of 4.4 per 100,000 Negro population. Females had a significantly higher rate than males, these being 6.2 and 2.3 respectively. The rates increased with age to a maximum of 29.3 at ages 54-59. The rates for females exceeded those for males at all ages. In general, females exceeded males in a decreasing ratio with advancing age.

The annual rate increased among Negroes from 3.6 in 1940 to 4.4 in 1950. Males and females both had increased rates during the decade. Males showed more significant increases, the rates growing at ages 45 and over.

The white population had an average annual rate of 11.7 per 100,000 white population in 1950, compared with 4.4 for

Negroes. The rate for white females, 15.8, was twice that for white males, 7.4, and both were significantly in excess of the corresponding rates for Negroes. The rates rose to a maximum of 47.9 at ages 55-59. They rose to a maximum of 64.9 among females at ages 50-54 and reached a maximum of 35.1 among males at ages 55-59. The rate for females was in excess at ages 40-44 in the ratio of 6.7 to 1. The rates continued in excess at higher ages, but in a decreasing ratio.

The rate of first admissions increased among whites from 7.5 in 1940 to 11.7 in 1950 (Table 30). Males and females both showed substantial increases. There were increases at all ages, though the rates of increase were highest after age 50.

Table 31 provides a summary comparison of rates of first admissions with involutional psychoses according to age for Negroes and whites in 1950. Throughout the age ranges, rates for Negroes were lower than those for whites.

Table 32 provides a summary based upon

# Mental disease among Negroes

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TABLE 28

*Negro first admissions with involutional psychoses to all hospitals for mental disease in New York State, 1949-51, classified according to age*

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
35-39 .....	-	3	3	-	3.2	2.5	-	2.0	1.1
40-44 .....	-	6	6	-	6.4	4.9	-	5.0	2.7
45-49 .....	7	30	37	24.1	32.3	30.3	7.8	30.2	19.5
50-54 .....	7	26	33	24.1	28.0	27.0	10.0	36.1	23.3
55-59 .....	10	17	27	34.5	18.3	22.1	22.4	35.9	29.3
60-64 .....	4	9	13	13.8	9.7	10.7	13.4	25.4	19.9
65-69 .....	1	2	3	3.4	2.2	2.5	4.6	6.8	5.9
TOTAL	29	93	122	100.0	100.0	100.0	2.3	6.2	4.4

standardized rates. Such rates increased among Negroes by 43%, rising from 8.6 in 1940 to 12.3 in 1950. The rate for females was significantly in excess of that for males in both years, but the rate for males grew

more rapidly. It advanced from 2.5 to 6.9. The rate for females increased from 15.0 to 18.1.

The rate for the white population increased from 16.4 to 24.0, an increase of

TABLE 29

*Average annual rates of first admissions with involutional psychoses among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
35-39 .....	-	2.0	1.1	-	2.9	1.6	-	0.69	0.69
40-44 .....	-	5.0	2.7	6.6	15.4	11.1	-	0.32	0.24
45-49 .....	7.8	30.2	19.5	1.8	36.8	19.4	4.33	0.82	1.01
50-54 .....	10.0	36.1	23.3	5.1	21.9	13.7	1.96	1.64	1.70
55-59 .....	22.4	35.9	29.3	3.9	28.9	16.9	5.74	1.24	1.75
60-64 .....	13.4	25.4	19.9	-	-	-	-	-	-
65-69 .....	4.6	6.8	5.9	-	-	-	-	-	-
TOTAL	2.3	6.2	4.4	1.2	5.7	3.6	1.92	1.09	1.22

TABLE 30

*Average annual rates of first admissions with involutional psychoses among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
25-29 .....	-	0.1	*	-	0.1	*	-	1.00	1.00
30-34 .....	-	0.6	0.3	-	0.1	0.1	-	6.00	3.00
35-39 .....	0.3	3.7	2.1	0.3	2.0	1.2	1.00	1.85	1.75
40-44 .....	3.5	23.6	13.8	4.9	19.1	12.0	0.71	1.24	1.15
45-49 .....	13.0	47.4	30.4	11.0	41.4	25.9	1.18	1.14	1.17
50-54 .....	27.0	64.9	46.1	21.3	49.8	35.0	1.27	1.30	1.32
55-59 .....	35.1	60.7	47.9	21.4	34.0	29.2	1.64	1.79	1.64
60-64 .....	30.1	39.0	34.5	12.0	18.8	15.4	2.51	2.07	2.24
65-69 .....	19.3	19.1	19.2	9.4	8.4	8.9	2.05	2.27	2.16
70-74 .....	6.6	5.4	5.9	2.2	3.3	2.8	3.00	1.64	2.11
75-79 .....	1.1	0.6	0.8	0.6	-	0.3	1.83	-	2.67
80-84 .....	0.7	1.1	0.9	-	-	-	-	-	-
85 or over....	-	1.0	0.6	-	-	-	-	-	-
TOTAL	7.4	15.8	11.7	4.4	10.5	7.5	1.68	1.50	1.56

\* Less than 0.05.

46%. Rates for males increased from 10.1 to 15.3. Those for females increased from 23.3 to 33.6.

Thus, standardized rates of first admissions with involutional psychoses increased among both Negroes and whites. In both years, however, the rates for Negroes were only about half those for whites. The difference was more marked among males.

#### MANIC-DEPRESSIVE PSYCHOSES

The manic-depressive psychoses represent a group of low frequency among Negroes. There were only 48 such first admissions during 1949-51, or an average annual rate of 1.7 per 100,000 Negroes. As is usual with

this group of psychoses, females had a higher rate than males, the rates being 2.4 and 0.9 for females and males respectively. With minor exceptions, females had higher rates at all ages from 20 to 69. Rates were highest at ages under 40, but no clear-cut trend appeared because of fluctuations due to small numbers.

The average annual rates for 1949-51 were less than those for 1939-41. Among Negro males the rates declined from 5.1 to 0.9. Among females they declined from 9.4 to 2.4. For both sexes combined they declined from 7.4 to 1.7, a decrease of 77%. Similar decreases occurred generally at all age levels (Table 34).



# Mental disease among Negroes

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TABLE 31

*Average annual rates of first admissions with involuntional psychoses among Negroes and whites to all hospitals for mental disease in New York State, 1949-51, per 100,000 corresponding population*

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
25-29 .....	-	-	-	-	0.1	*	-	-	-
30-34 .....	-	-	-	-	0.6	0.3	-	-	-
35-39 .....	-	2.0	1.1	0.3	3.7	2.1	-	0.54	0.52
40-44 .....	-	5.0	2.7	3.5	23.6	13.8	-	0.21	0.20
45-49 .....	7.8	30.2	19.5	13.0	47.4	30.4	0.60	0.64	0.64
50-54 .....	10.0	36.1	23.3	27.0	64.9	46.1	0.37	0.56	0.51
55-59 .....	22.4	35.9	29.3	35.1	60.7	47.9	0.64	0.59	0.61
60-64 .....	13.4	25.4	19.9	30.1	39.0	34.5	0.44	0.65	0.58
65-69 .....	4.6	6.8	5.9	19.3	19.1	19.2	0.24	0.36	0.31
70-74 .....	-	-	-	6.6	5.4	5.9	-	-	-
75-79 .....	-	-	-	1.1	0.6	0.8	-	-	-
80-84 .....	-	-	-	0.7	1.1	0.9	-	-	-
85-89 .....	-	-	-	-	1.0	0.6	-	-	-
TOTAL	2.3	6.2	4.4	7.4	15.8	11.7	0.31	0.39	0.38

\* Less than 0.05.

TABLE 32

*Average annual standardized \* rates of first admissions with involuntional psychoses among Negroes and whites to all hospitals for mental disease in New York State, per 100,000 population, 1949-51 and 1939-41*

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	1940	Ratio	1950	1940	Ratio	1950	1940
Males .....	6.9 ± 1.38	2.5 ± 1.03	2.76	15.3 ± 0.46	10.1 ± 0.40	1.51	0.45	0.24
Females ....	18.1 ± 2.04	15.0 ± 2.39	1.21	33.6 ± 0.66	23.3 ± 0.60	1.44	0.54	0.64
TOTAL	12.3 ± 1.74	8.6 ± 1.32	1.43	24.0 ± 0.41	16.4 ± 0.36	1.46	0.51	0.52

\* Population of New York State aged 35 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

TABLE 33

*Negro first admissions with manic-depressive psychoses to all hospitals for mental disease in New York State, 1949-51, classified according to age*

AGE (years) *	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
20-24 .....	1	8	9	8.8	22.2	18.7	1.0	5.4	3.6
25-29 .....	3	8	11	25.0	22.2	22.9	2.2	4.6	3.6
30-34 .....	4	4	8	33.3	11.1	16.7	3.4	2.5	2.9
35-39 .....	1	6	7	8.8	16.7	14.6	0.9	4.0	2.6
40-44 .....	1	4	5	8.8	11.1	10.4	1.3	3.3	2.2
45-49 .....	-	1	1	-	2.8	2.1	-	1.0	0.5
50-54 .....	-	1	1	-	2.8	2.1	-	1.4	0.7
55-59 .....	1	2	3	8.8	5.6	6.2	2.2	4.2	3.3
60-64 .....	1	1	2	8.8	2.8	4.2	3.4	2.8	3.1
65-69 .....	-	1	1	-	2.8	2.1	-	3.4	2.0
TOTAL	12	36	48	100.0	100.0	100.0	0.9	2.4	1.7

TABLE 34

*Average annual rates of first admissions with manic-depressive psychoses among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
15-19 .....	-	-	-	4.9	9.8	7.6	-	-	-
20-24 .....	1.0	5.4	3.6	15.9	7.4	10.4	0.06	0.73	0.34
25-29 .....	2.2	4.6	3.6	9.3	16.2	13.4	0.24	0.28	0.27
30-34 .....	3.4	2.5	2.9	6.2	17.2	12.4	0.54	0.14	0.23
35-39 .....	0.9	4.0	2.6	3.4	18.4	11.6	0.26	0.22	0.22
40-44 .....	1.3	3.3	2.2	1.3	11.6	6.5	1.00	0.28	0.34
45-49 .....	-	1.0	0.5	14.3	8.8	11.5	-	0.11	0.04
50-54 .....	-	1.4	0.7	7.7	7.3	7.4	-	0.19	0.09
55-59 .....	2.2	4.2	3.3	3.9	3.6	3.7	0.56	1.17	0.89
60-64 .....	3.4	2.8	3.1	-	-	-	-	-	-
65-69 .....	-	3.4	2.0	-	-	-	-	-	-
TOTAL	0.9	2.4	1.7	5.1	9.4	7.4	0.17	0.26	0.23

# Mental disease among Negroes

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Crude rates for whites exceeded those for Negroes. White males had a rate of 3.8; white females had a rate of 7.1. The average for both sexes was 5.4. The rates rose to a maximum of 10.6 at ages 40-44. Female rates rose to a maximum of 13.0, male rates to a maximum of 8.1, both at ages 40-44. Female rates were in excess through ages 65-69, but in a generally decreasing ratio. Thus, at ages 25-29 the female rate was in excess in the ratio of 3.51 to 1. The ratios declined steadily to only 1.06 to 1 at ages 50-54.

Rates of first admissions with manic-depressive psychoses decreased among whites between 1940 and 1950 but at a lesser rate

than among Negroes (Table 35). They decreased among males by 33%, from 5.7 in 1940 to 3.8 in 1950. They decreased among females from 11.9 to 7.1, or by 40%. For both sexes combined the rates declined from 8.8 to 5.4, or by 61%. In general, rates of decrease were greater at younger ages, for example, under age 40.

Annual rates for Negroes and whites for 1950 are compared in Table 36. At every age rates for Negroes were significantly less than those for whites.

Final comparisons appear in Table 37, where the rates for 1940 and 1950 for both races were standardized on a common basis. The decrease in rates of first admissions

TABLE 35

*Average annual rates of first admissions with manic-depressive psychoses among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
10-14 .....	0.1	0.2	0.1	0.1	0.2	0.2	1.00	1.00	0.50
15-19 .....	2.0	2.2	2.1	2.8	5.3	4.1	0.71	0.42	0.51
20-24 .....	3.2	8.3	5.9	6.6	14.6	10.7	0.48	0.57	0.56
25-29 .....	3.1	10.9	7.2	7.0	16.9	12.2	0.44	0.64	0.59
30-34 .....	4.4	11.5	8.1	7.4	22.5	15.1	0.59	0.51	0.54
35-39 .....	5.7	13.4	9.7	7.8	25.5	16.7	0.73	0.53	0.58
40-44 .....	8.1	13.0	10.6	9.8	17.6	13.7	0.83	0.74	0.77
45-49 .....	6.7	10.4	8.5	11.0	16.0	13.4	0.61	0.65	0.63
50-54 .....	7.7	8.2	8.0	9.9	14.1	11.9	0.78	0.58	0.67
55-59 .....	5.4	8.7	7.0	7.8	10.9	9.3	0.69	0.80	0.75
60-64 .....	5.1	7.7	6.4	6.9	9.4	8.2	0.74	0.82	0.78
65-69 .....	4.5	6.0	5.3	2.7	7.3	5.1	1.67	0.82	1.04
70-74 .....	4.4	3.2	3.8	1.6	4.7	3.3	2.75	0.68	1.15
75 or over....	1.0	1.1	1.1	0.9	0.4	0.7	1.11	2.75	1.57
TOTAL	3.8	7.1	5.4	5.7	11.9	8.8	0.67	0.60	0.61



TABLE 36

Average annual rates of first admissions with manic-depressive psychoses among Negroes and whites to all hospitals for mental disease in New York State, 1949-51, per 100,000 corresponding population

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
10-14 .....	-	-	-	0.1	0.2	0.1	-	-	-
15-19 .....	-	-	-	2.0	2.2	2.1	-	-	-
20-24 .....	1.0	5.4	3.6	3.2	8.3	5.9	0.31	0.65	0.61
25-29 .....	2.2	4.6	3.6	3.1	10.9	7.2	0.71	0.42	0.50
30-34 .....	3.4	2.5	2.9	4.4	11.5	8.1	0.77	0.22	0.36
35-39 .....	0.9	4.0	2.6	5.7	13.4	9.7	0.16	0.30	0.27
40-44 .....	1.3	3.3	2.2	8.1	13.0	10.6	0.16	0.25	0.21
45-49 .....	-	1.0	0.5	6.7	10.4	8.5	-	0.10	0.06
50-54 .....	-	1.4	0.7	7.7	8.2	8.0	-	0.17	0.09
55-59 .....	2.2	4.2	3.3	5.4	8.7	7.0	0.41	0.48	0.47
60-64 .....	3.4	2.8	3.1	5.1	7.7	6.4	0.67	0.36	0.48
65-69 .....	-	3.4	2.0	4.5	6.0	5.3	-	0.57	0.38
70-74 .....	-	-	-	4.4	3.2	3.8	-	-	-
75 or over....	-	-	-	1.0	1.1	1.1	-	-	-
TOTAL	0.9	2.4	1.7	3.8	7.1	5.4	0.24	0.34	0.31

TABLE 37

Average annual standardized \* rates of first admissions with manic-depressive psychoses among Negroes and whites to all hospitals for mental disease in New York State, per 100,000 population, 1949-51 and 1939-41

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	1940	Ratio	1950	1940	Ratio	1950	1940
Males .....	1.3 ± 0.44	6.2 ± 1.19	0.21	5.0 ± 0.21	7.2 ± 0.25	0.69	0.26	0.86
Females ....	2.8 ± 0.57	9.7 ± 1.34	0.29	9.1 ± 0.27	14.8 ± 0.36	0.61	0.31	0.66
TOTAL	2.1 ± 0.37	8.0 ± 0.90	0.26	7.1 ± 0.17	11.1 ± 0.22	0.64	0.30	0.72

\* Population of New York State aged 15 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

# Mental disease among Negroes

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TABLE 38

*Negro first admissions with dementia praecox to all hospitals for mental disease in New York State, 1949-51, classified according to age*

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
under 10.....	9	3	12	0.6	0.2	0.4	3.7	1.3	2.5
10-14 .....	40	50	90	2.9	3.6	3.2	45.7	55.1	50.4
15-19 .....	136	119	255	9.7	8.6	9.1	169.0	124.1	144.6
20-24 .....	326	186	512	23.3	13.4	18.4	312.4	125.1	202.3
25-29 .....	336	270	606	24.0	19.4	21.7	249.2	156.1	196.9
30-34 .....	226	232	458	16.1	16.7	16.4	189.8	147.5	165.7
35-39 .....	147	235	382	10.5	16.9	13.7	125.4	154.8	142.0
40-44 .....	89	131	220	6.4	9.4	7.9	86.9	108.7	98.7
45-49 .....	50	73	123	3.6	5.3	4.4	55.6	73.5	65.0
50-54 .....	26	53	79	1.9	3.8	2.8	37.3	73.6	55.7
55-59 .....	7	17	24	0.5	1.2	0.9	15.7	35.9	26.1
60-64 .....	3	13	16	0.2	0.9	0.6	10.1	36.7	24.5
65-69 .....	2	4	6	0.1	0.3	0.2	9.2	13.6	11.7
70-74 .....	1	2	3	0.1	0.1	0.1	8.3	12.0	10.4
75-79 .....	-	1	1	-	0.1	*	-	9.8	6.4
Unascertained	2	-	2	0.1	-	0.1	-	-	-
TOTAL	1400	1389	2789	100.0	100.0	100.0	110.8	92.9	101.1

\* Less than 0.05.

with manic-depressive psychoses is clearly evident. Among Negroes the rates declined by three-fourths, from 8.0 to 2.1. The rates for Negro males declined from 6.2 to 1.3, or by 80%. For females they declined from 9.7 to 2.8, or by 30%.

The rates also decreased among the white population, but at a lesser rate. Among males they decreased from 7.2 to 5.0, or by 30%; among females they declined from 14.8 to 9.1, or by 40%. The average for both sexes decreased by a third, from 11.1 to 7.1.

In each year the white population had higher rates of manic-depressive psychoses

than did Negroes. In 1940 the rate for whites exceeded that for Negroes by 38%. In 1950 the rate for whites was again in excess but the disparity had grown, the excess amounting to 238%.

Thus, in contrast to the general relative distribution of the psychoses, Negroes definitely have lower rates than whites for the manic-depressive group. This cannot be explained by any of the environmental factors listed previously. We are therefore left with the hypothesis that the difference may result from racial characteristics, which, in this respect, are more favorable to Negroes.

## DEMENTIA PRAECOX

The outstanding diagnostic category is dementia praecox. There were 2,789 such first admissions among Negroes during 1949-51 inclusive, giving an average annual rate of 101.1 per 100,000 Negro population. Males and females had rates of 110.8 and 92.9 respectively.

Dementia praecox is primarily a disease of the young. Half of such Negro first admissions were under 30 years of age. More than two-thirds were under age 35. Rates of first admissions are therefore weighted towards the young. There were very few first admissions with dementia praecox under age 10, but at ages 10-14 there was an average annual rate of 50.4. This increased rapidly to a maximum of 202.3 at ages 20-24

and then decreased steadily with advancing age. Through ages 30-34 male rates, with one exception, exceeded those for females. Beyond age 35 females had higher rates. The excess of the rates for females increased with advancing age.

Negro rates of first admissions with dementia praecox increased by 51%, from 67.0 in 1940 to 101.1 in 1950. The male rate increased more rapidly than that for females, advancing from 67.5 to 110.8, an increase of 64%. The female rate increased from 66.7 to 92.9, or by 39%. In general, the rates increased during the decade at all ages, but in higher ratios at the younger ages.

The white population had lower rates than Negroes. The average rate was 33.2

TABLE 39

*Average annual rates of first admissions with dementia praecox among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
10-14 .....	45.7	55.1	50.4	7.6	1.4	5.2	6.01	39.36	9.69
15-19 .....	169.0	124.1	144.6	95.1	85.6	90.0	1.78	1.45	1.61
20-24 .....	312.4	125.1	202.3	189.8	89.2	128.0	1.64	1.40	1.58
25-29 .....	249.2	156.1	196.9	142.3	105.5	122.3	1.75	1.48	1.61
30-34 .....	189.8	147.5	165.7	112.0	117.7	115.2	1.69	1.25	1.44
35-39 .....	125.4	154.8	142.0	75.7	102.8	90.4	1.66	1.51	1.57
40-44 .....	86.9	108.7	98.7	59.5	63.0	61.3	1.46	1.73	1.61
45-49 .....	55.6	73.5	65.0	37.5	70.2	54.0	1.48	1.04	1.20
50-54 .....	37.3	73.6	55.7	33.2	26.7	29.9	1.12	2.76	1.86
55-59 .....	15.7	35.9	26.1	27.2	61.7	44.9	0.58	0.58	0.58
60-64 .....	10.1	36.7	24.5	-	21.7	11.3	-	1.69	2.17
65-69 .....	9.2	13.6	11.7	9.2	14.0	11.9	1.00	0.97	0.98
70-74 .....	8.3	12.0	10.4	-	-	-	-	-	-
75 or over....	-	5.8	3.8	-	-	-	-	-	-
TOTAL	110.8	92.9	101.1	67.5	66.7	67.0	1.64	1.39	1.51



# Mental disease among Negroes

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TABLE 40

*Average annual rates of first admissions with dementia praecox among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41*

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
10-14 .....	7.4	5.4	6.4	1.6	1.8	1.7	4.63	3.00	3.76
15-19 .....	52.6	42.8	47.6	33.1	26.8	30.0	1.59	1.60	1.59
20-24 .....	100.1	62.8	80.5	64.2	44.4	54.1	1.56	1.41	1.49
25-29 .....	83.6	73.4	78.3	61.4	51.7	56.4	1.36	1.42	1.39
30-34 .....	60.7	69.6	65.4	51.7	46.8	49.2	1.17	1.49	1.33
35-39 .....	50.5	61.1	56.1	41.5	48.5	45.0	1.22	1.26	1.24
40-44 .....	38.0	47.0	42.6	29.5	33.8	31.9	1.29	1.39	1.34
45-49 .....	26.2	34.7	30.4	22.1	27.3	24.6	1.19	1.27	1.23
50-54 .....	16.6	22.9	19.8	13.7	18.6	16.0	1.21	1.23	1.24
55-59 .....	12.3	17.2	14.7	10.0	14.1	12.0	1.23	1.22	1.23
60-64 .....	7.3	10.9	9.1	4.3	7.4	5.9	1.70	1.47	1.54
65-69 .....	3.8	6.4	5.2	2.4	4.4	3.4	1.58	1.45	1.53
70-74 .....	1.1	2.5	1.8	—	2.1	1.1	—	1.19	1.64
75 or over ...	1.3	1.9	1.6	1.2	1.9	1.6	1.08	1.00	1.00
TOTAL	33.0	33.4	33.2	26.7	25.7	26.2	1.24	1.30	1.27

per 100,000 white population. Males and females had essentially equal crude rates. White first admissions with dementia praecox were significantly older than Negroes, and in both groups females were older than males.

Among whites the rate rose to a maximum of 80.5 at ages 20-24, and then fell steadily with advancing age. The maximum rate, 100.4, was reached by males at ages 20-24, but the maximum for females, 73.4, occurred at ages 25-29. Male rates were in excess through the latter age interval, but were exceeded subsequently by females. As with Negroes the rates for females exceeded those for males in an increasing ratio after the early years.

Between 1940 and 1950 the rate for whites

increased by 27%, from 26.2 to 33.2. The male rate increased from 26.7 to 33.0, or by 24%. The female rate increased from 25.7 to 33.4, or by 30%. The rates of increase were less than those for Negroes. Among whites, as among Negroes, the rates increased during the decade at all ages, but, in general, rates for females increased more rapidly.

In 1950 the Negro rate exceeded that of whites in the ratio of 3.04 to 1. The excess was greater among males, Negroes being in excess in the ratio of 3.36 to 1. There was a smaller differential among females, Negroes being in excess in the ratio of 2.78 to 1. Throughout the age range the rates for Negroes exceeded those for whites.

The general Negro population of New

York State is younger than the white population. This influences the relative distribution of dementia praecox. Table 42 therefore provides summary rates on the basis of a common standard.

On this basis the standardized rates all showed increases during the decade. Among Negroes the rate increased from 71.8 in 1940 to 109.0 in 1950. The increase was relatively greater for males, among whom the rate increased from 73.4 to 119.7, an increase of 63%. The rates for females increased by 41%, from 70.1 to 98.6. Thus, the ratio of the male to female rate increased from 1.04 to 1 in 1940 to 1.21 to 1 in 1950.

The white population also increased its rates of first admissions with dementia praecox, though at a lesser ratio. Thus, the

rate increased from 31.3 to 71.8, or by 36%, compared with an increase of 52% for Negroes. Rates increased among white males from 31.8 to 42.7, or by 34%, compared with 63% among Negroes. Rates for white females increased from 30.6 to 42.4, about equal to the ratio for Negro females.

Because of differences in the relative rates of increase, the difference in rates of first admissions between Negroes and whites increased during the decade. Thus, the Negro rate exceeded that for whites in 1940 in the ratio of 2.29 to 1, but this increased to a ratio of 2.55 to 1 in 1950. The increase was more substantial for males, the Negro rate being in excess in the ratio of 2.31 to 1 in 1940 but in excess in a ratio of 2.80 to 1 in 1950. The rate for Negro females was in

TABLE 41

*Average annual rates of first admissions with dementia praecox among Negroes and whites to all hospitals for mental disease in New York State, 1949-51, per 100,000 corresponding population*

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
10-14 .....	45.7	55.1	50.4	7.4	5.4	6.4	6.18	10.20	7.88
15-19 .....	169.0	124.1	144.6	52.6	42.8	47.6	3.21	2.90	3.04
20-24 .....	312.4	125.1	202.3	100.1	62.8	80.5	3.12	1.99	2.51
25-29 .....	249.2	156.1	196.9	83.6	73.4	78.3	2.98	2.13	2.51
30-34 .....	189.8	147.5	165.7	60.7	69.6	65.1	3.13	2.12	2.53
35-39 .....	125.4	154.8	142.0	50.5	61.1	56.1	2.48	2.53	2.53
40-44 .....	86.9	108.7	98.7	38.0	47.0	42.6	2.29	2.31	2.32
45-49 .....	55.6	73.5	65.0	26.2	34.7	30.1	2.12	2.12	2.14
50-54 .....	37.3	73.6	55.7	16.6	22.9	19.8	2.24	3.21	2.81
55-59 .....	15.7	35.9	26.1	12.3	17.2	14.7	1.28	2.09	1.78
60-64 .....	10.1	36.7	24.5	7.3	10.9	9.1	1.38	3.37	2.69
65-69 .....	9.2	13.6	11.7	3.8	6.4	5.2	2.42	2.13	2.25
70-74 .....	8.3	12.0	10.4	1.1	2.5	1.8	7.54	4.80	5.78
75 or over....	-	5.8	3.8	1.3	1.9	1.6	-	3.05	2.38
TOTAL	110.8	92.9	101.1	33.0	33.4	33.2	3.36	2.78	3.04

TABLE 42

*Average annual standardized \* rates of first admissions with dementia praecox among Negroes and whites to all hospitals for mental disease in New York State, per 100,000 population, 1949-51 and 1939-41*

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	1940	Ratio	1950	1940	Ratio	1950	1940
Males . . . . .	119.7 $\pm$ 4.18	73.4 $\pm$ 4.08	1.63	42.7 $\pm$ 0.61	31.8 $\pm$ 0.53	1.34	2.80	2.31
Females . . . .	98.6 $\pm$ 3.40	70.1 $\pm$ 3.59	1.41	42.4 $\pm$ 0.59	30.6 $\pm$ 0.52	1.39	2.33	2.29
TOTAL	109.0 $\pm$ 2.66	71.8 $\pm$ 2.70	1.52	42.7 $\pm$ 0.43	31.3 $\pm$ 0.37	1.36	2.55	2.29

\* Population of New York State aged 15 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

excess in both years, but the relative increase was not substantially different in 1950.

#### SUMMARY

This analysis of the frequency of mental disease among Negroes is based upon first admissions to all hospitals for mental disease in New York State during three years beginning October 1, 1948 and ending September 30, 1951. Comparisons were made with similar admissions during the preceding decade. Further comparisons were made with the white population of New York State during the same period.

Our first conclusion is that there are no racial differences between Negroes and whites with respect to mental disease—that is, there are no mental diseases which are limited to one race or the other. The same mental diseases occur among both races but in different relative frequencies.

The most frequent mental disorder is dementia praecox. A total of 45.2% of the Negro first admissions were included in this group, compared with 26.9% of whites. On the other hand, a third of the white first

admissions were included in psychoses with cerebral arteriosclerosis and senile psychoses compared with only a sixth of the Negroes. General paresis included 7.7% of the Negroes and only 1.2% of the whites. The alcoholic psychoses included 8.7% of the Negroes, 5.3% of whites.

These differences were produced in part by the different age structures of the populations. Negroes in general were a younger population. It was necessary to achieve comparability by standardizing the rates of first admissions.

On this basis Negroes had a rate of 325.8 per 100,000 population, compared with 153.8 for whites. Furthermore, the rate for Negroes dropped by 14% between 1940 and 1950, whereas that for whites increased by 5%. The excess of the Negro rate dropped from 157% in 1940 to 112% in 1950.

The rate for Negro males decreased from 435.1 in 1940 to 365.2 in 1950; that of female Negroes decreased from 312.6 to 280.5. Rates for white males and females increased during the decade, though the increase among males was not significant.

The standardized rate for general paresis



dropped by 46% among Negroes. It fell from 49.4 to 26.7. Both sexes shared in the decrease, which was relatively greater for males. The decrease in rates of general paresis contrast with an increase during the period 1930-40.

General paresis also decreased among whites, the standardized rates decreasing from 7.4 to 1.9. The Negro rate was in excess in the ratio of 6.68 to 1 in 1940, but because of the more rapid decrease among whites the excess of the Negro rate increased to a ratio of 14.05 to 1 in 1950.

The standardized rate for alcoholic psychoses decreased among Negroes from 36.0 to 27.0. This was due almost entirely to a decrease of 31% among males from a rate of 58.8 to 40.8. The rate for Negro females was practically constant during the decade. Rates for whites decreased from 9.8 to 9.0. Again, this resulted from a decrease of 12% among males; on the contrary, the rate increased among white females from 3.3 to 3.8. Rates for Negroes were in excess in 1950 in the ratio of 3 to 1. The Negro rate in 1940 was in excess in the ratio of 3.67 to 1.

Psychoses with cerebral arteriosclerosis were reduced slightly among whites from a rate of 73.0 in 1940 to 71.1 in 1950. The rate decreased significantly among Negroes, however, from 253.2 to 180.7. The Negro excess was reduced from a ratio of 3.47 to 1 in 1940 to 2.54 to 1 in 1950. The disparity between Negro males and females increased from 8% in 1940 to 21% in 1950.

Senile psychoses increased among whites from a rate of 45.2 in 1940 to 50.9 in 1950. Among Negroes, however, the corresponding rates fell from 109.0 to 80.8. The decrease was relatively greater among Negro males. In 1940 Negro males and females had equal rates of such psychoses, but in 1950 the rate for females was in excess by 25%.

The involutional psychoses were one of

two major groups which increased in frequency among Negroes. The standardized rate rose from 8.6 to 12.3. Rates rose similarly among whites from 16.4 to 24.0, the rate of increase being the same as for Negroes. It is significant, however, that the rate for Negroes was only half that for whites.

The standardized rate for manic-depressive psychoses decreased among Negroes from 8.0 to 2.1, a decrease of 74%. These psychoses also decreased among whites from 11.1 to 7.1, or by 36%. In both 1940 and 1950 rates for Negroes were less than those for whites. In 1950 the Negro rate was only 30% of that for whites.

In 1940 Negroes had a standardized rate of 71.8 for dementia praecox, compared with 31.3 for whites, or an excess of 129%. In 1950 the rate grew among Negroes to 109.0, an increase of 52%, and grew among whites to 42.7, an increase of 36%. The excess of the Negro rate increased to 155%. The rate for Negro males was significantly higher than that for Negro females. Among whites the sexes had equivalent rates.

Thus, it is clear that except for the involutional psychoses and dementia praecox there was a decrease in the rate of first admissions among Negroes between 1940 and 1950. This represents a significant change from the trend between 1930 and 1940. Despite the decrease of rates, however, those for Negroes remained in substantial excess over those for whites, with the exception of involutional psychoses and manic-depressive psychoses. The significance of the latter, especially for the manic-depressive group, is not fully understood, and raises questions as to the possibility of different degrees of emotional reactions.

The great majority of the differences are explicable, however, on the basis of migration and environment. It has been demon-

## *Mental disease among Negroes*

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strated that migratory groups have higher rates of mental disease as measured by rates of first admissions.<sup>5</sup> Negroes in New York State are a highly migratory population, 60% having been born outside of New York State, compared with only 14% of the white population. In addition, Negroes suffer from low standards of living owing to economic disabilities. These disabilities were evidently less severe in 1950 than in 1940, as measured by economic and educational

advances and by the wider dispersion of the Negro population within New York City. These have reduced, in general, the rates of first admissions among Negroes, and therefore point to the possibility of further improvement in the mental health of Negroes in New York State.

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<sup>5</sup> Malzberg, Benjamin and Everett S. Lee, *Migration and Mental Disease: A Study of First Admissions to Hospitals for Mental Disease, New York, 1939-41*. New York, Social Science Research Council, 1956.

# Book Reviews

## STUDIES ON HYSTERIA

By Josef Breuer and Sigmund Freud

Translated and edited by James Strachey,  
with the collaboration of Anna Freud

New York, Basic Books, 1957. 335 pp.

This book rates more than routine interest in view of its historical position in psychiatry. It is the only major exposition of the collaborative work of Josef Breuer and Sigmund Freud, whose early concepts helped substantially in laying the foundations for modern dynamic psychiatry.

The cases and discussion in *Studies on Hysteria* provided a great impetus to a more general recognition of the psychological origins of what is today fully accepted as an emotional illness. Only 70 years ago this was not true at all. Then, around 1890, Charcot first reproduced hysterical symptoms, under hypnosis. Independently, and also stimulated by this, Breuer and Freud studied their bases, developed methods to further explore intrapsychic phenomena, and introduced several important concepts, presenting their findings and views in this interesting volume.

Herein they advance the important concept of "the unbearable idea" and the subsequent handling of this by the psyche. The unconscious, as a repository of consciously disowned data, is firmly established. Detailed case studies are presented and analyzed.

Another major concept, arrived at simultaneously by the authors and named by Freud, is conversion. Conversion is the name for the unconscious process through which intrapsychic conflicts, which would otherwise give rise to anxiety if they gained consciousness, instead obtain symbolic external expression. Since its introduction

this conception has been developed and widened, so that today it is universally accepted. One may properly refer to somatic conversions, physiologic conversions, psychologic conversions and behavioral conversions. There is no up-to-date textbook in the behavioral sciences which does not utilize this term and associated ideas which were first advanced (with one early paper as an exception) in this volume.

Much of our subsequent research into the psychologic factors in mental and emotional illness has been based upon the early study of hysteria. The present volume, carefully retranslated and edited, is the first milestone in this direction. This book is accordingly recommended to all those who have an interest in the background and origins of modern psychiatry—HENRY P. LAUGHLIN, M.D., Chevy Chase, Md.

## YEARBOOK OF EDUCATION

George Z. F. Bereday and  
Joseph A. Lauwerys, eds.

Yonkers-on-Hudson, World Book Co., 1958. 544 pp.

Mental health in education is treated with unusual care and thoroughness in the 1958 Yearbook of Education, which deals particularly with the secondary school curriculum. The terms *mental health* and *mental hygiene* are not particularly happy ones, however, in the opinion of W. D. Wall, who starts the discussion.

Dr. Wall says: "In the eyes of many, lay and professional alike, they suggest the area of mental ill health: psychiatric after-care service, maladjustment, care for mentally subnormal children and adults and the like, important preoccupations with which educationists are deeply concerned, but which are by no means coterminous with educa-



tion. Not unnaturally, too, the terms in the mouths and writings of those whose profession it is to deal with the markedly abnormal are suspect to those whose pre-occupations lie with the normal child, his teacher, and his parents. A certain legitimately healthy resistance to what is often understood as the 'psychiatrization' of education has thus grown up; and, fortunately, it must be said, has protected the schools from well-intentioned meddling by those who, whatever their professional qualifications and insights in other fields, are too often the veriest amateurs as far as the teaching of children and adolescents is concerned."

In her discussion of mental health and the secondary school curriculum Bernice Milburn Moore of the Hogg Foundation, University of Texas, emphasizes the transition from a static definition of the mentally healthy person as "adjusted" to the dynamic concept of the personality as continuously adjusting, re-adjusting, changing and growing—no matter at what age. A close second in importance, she says, is "the study of healthy personality perceived as positive in development through effective socialization and interpersonal relations from infancy through childhood into youth and throughout adult years." Mental health then, Dr. Moore says, "by its coincidence in definition with the healthy personality—the normal personality—and by its concern for the development of effective, satisfying behavior relationships and action in society, is looked upon by many educators as a primary function of the schools."

Discussing the mental health implications of secondary education specifically, Dr. Moore says: "In the secondary schools of the United States recent attempts have been made not only to educate teachers in mental health, but to offer group experiences especially designed to acquaint youth with the

dynamics of human behavior and the bases for effective interpersonal relations. Designation of these courses varies: Personal problems, personal relationships, human relations, personal and family living, home and family life education are some of the more prevalent.

"Perhaps the greatest opportunity to advance in the secondary curriculum as far as mental health of youth is concerned is in the application of sociological and social psychological principles of the group process to the learning of content. This blending of the traditional educational function of teaching facts with emotional and social participation as group members could make as radical a change in secondary education as has come in the education of the younger child."

Special emphasis in Dr. Moore's article is on the teacher. "To say that the teacher of youth should be a normal, healthy personality is to state the obvious," she says. "Morale and *rapprochement* in small groups depend to a large degree upon the leader. Teachers are, first and last, group leaders in an educational experience. Healthy personalities in teachers provide the best insurance secondary schools can offer that their educational practices, standards and philosophy will contribute to the emotional development of youth as they become normal adult personalities, productive and creative."—W. CARSON RYAN, Chapel Hill.

## PSYCHOTHERAPY OF THE ADOLESCENT

Benjamin Harris Balser, M.D., ed.

New York, International Universities Press, 1957.  
270 pp.

Psychotherapy of the young adolescent is perhaps the greatest challenge to a psychia-

trist. Whether the young patient accepts treatment on his own or is urged or even ordered to accept therapy by the courts, the challenge continues to remain frustrating and even baffling to many a psychiatrist who deals with this age level.

To this end, then, Dr. Balser has very carefully selected a group of authorities in the field who, through their own personal experiences, have added materially to this very needed and necessary discipline. The management of the young adolescent is presented in various facets: psychotherapy in private practice, psychotherapy at school with inpatient treatment, psychotherapy of the adolescent in the clinic, or combined clinic and inpatient treatment, and finally psychotherapy of the adolescent in intensive hospital treatment.

This short tome becomes even more interesting when other collaborators present discussions of the various techniques with constructive criticism. To add a more personal component, one of the contributors presents a complete psychotherapeutic interview with an adolescent patient—a recording with dynamic comments. In addition, a schoolmaster, from his personal point of view, presents the psychotherapy of an adolescent.

Every one of the authors agrees that restlessness, confusion, impatience, instability, fluctuations of enthusiasm, infatuation, laziness, forgetfulness and inconsistencies are the challenge of the adolescent. They all agree that this age is still very much not completely understood and requires considerable understanding before any definitive attitudes can be presented for this highly complicated developmental period. With no exception they are in agreement that this type of patient requires continuing concentrated effort to unravel the mysteries of his position between childhood and young adulthood.

This book is a useful adjunct for the medical student, the psychiatric intern or resident in training, the social worker, and certainly for the psychiatrist in active practice.—LOUIS D. BOSHERS, M.D., Chicago.

## THE CHRONICALLY ILL

By Joseph Fox, Ph.D.

*New York, Philosophical Library, 1957. 229 pp.*

Dr. Fox, director of the Home for Chronic Sick in Irvington, N. J., has drawn on his vast experience in the field in compiling this volume. He gives due consideration to the complexities involved in a work of this kind, and they are many, treating in turn the various aspects and problems encountered therein, and elaborating so far as the limitation of a single volume would permit.

This work will appeal equally to the seasoned specialist and the aspiring student who contemplates entering this field, and will provide a ready reference book of the most modern available knowledge and expert opinion. In its highly compressed nine chapters will be found an abundance of statistical analyses, and tabulations of facts and figures which have been obtained from the records of institutions throughout the country, and more especially from those in Maryland.

Stressing the point that may well alarm the average reader, Dr. Fox states that half the available bed space in the hospitals throughout the country is devoted to the care of the chronically mentally ill. The chronically ill, as distinguished from the mentally ill, occupy 45,000 beds, leaving 272,000 unprovided for; and the mentally ill are provided with 441,000 beds, with no provision for 352,000. These are staggering figures, and with increasing longevity

the problem of caring for the chronically ill becomes an ever-expanding one.

The author maintains that fully 75% of all chronically ill cases are homebound but that changing economics will in the future lower the number that receive home care. As for the mentally ill, while a large number of them are by no means incurable, still they require long-term care and overtax the available facilities.

Dr. Fox offers no panacea that will solve the problem. In the present work he describes conditions as they are today from the viewpoints of the medical supervisor, the victim, the institution and all others involved in the care of the chronically ill. Most of us will agree with him in believing that the nearest solution must be an enlarged and augmented program undertaken by the state.

The casual lay reader will be apt to find this book somewhat repetitious, but to those closest to the problem it should prove an incalculable aid.—MOTHER M. BERNADETTE DE LOURDES, Mary Manning Walsh Home, New York City.

## HANDBOOK OF SPEECH PATHOLOGY

Lee Edward Travis, ed.

New York, Appleton-Century-Crofts, 1957. 1,088 pp.

Handbooks, reviews, encyclopedias and summary treatments of the subject matter in psychology and related fields have become the fashion. The routine excuse for such publications is, in L. E. Travis's own words, the fact that the science or, in this case, "speech pathology has grown away beyond the grasp of one man."

Publishers seemingly accept manuscripts of reference books with fewer compunctions than they do works of original scientific in-

vestigators. This practice often results in the publication of compendia containing a hodgepodge of unrelated articles of variable and inferior quality printed more for the benefit of the authors than the readers.

Fortunately, the *Handbook of Speech Pathology* is not just another such reference text. It is, in fact, a remarkable tome that might serve as a model for other scientific publications of its type.

Its 27 contributors are without exception either leading clinicians or research men in speech pathology. Their writing is uniformly superior. Verbal artistry as a substitute for knowledge is rare in its 1,088 pages.

The book is crammed with well-organized facts and long-incubated ideas. A sense of reality sustained by thoroughly assimilated experience takes precedence over doctrine, bias and self-defense in all departments, even in the section on psychotherapy.

My impression is that speech pathologists have reached an enviable level of ethical and professional maturation. An awareness of their delicate yet crucial position among other professionals is evident throughout the book. It tends to evoke in the reader a feeling of confidence in their achievement and also a sense of humility for what is not yet known.

The handbook is an ambitious, perhaps overambitious, undertaking, some will say. It has four parts: Part I, Basic Considerations in Speech Pathology, deals in eight solid chapters with developmental, neurophysiological, acoustic, phonetic and diagnostic problems, including instrumentation. Part II contains 14 chapters on speech anomalies related to deafness, aphasia, mental retardation, cerebral palsy and the malformations of speech organs. Part III includes eight highly informative chapters on the so-called functional articulation defects and on stuttering. Part IV concerns itself



with problems of psychotherapy and speech therapy.

Speech pathologists are beset by the dilemmas typical of other fields. They have not conquered the perennial challenges of such dichotomies as organic and functional, environmental and genetic, individual and group, intrapersonal and interpersonal, form and contents, skill and application, drill and motivation, child and parent, cause and effect. Yet they have coped with these annoying questions in more skillful and more realistic ways than can be found in other disciplines.

The handbook offers a most rewarding course of study for neurologists, psychiatrists, pediatricians, clinical and school psychologists, guidance counselors and speech therapists. In child welfare work hardly a day passes without the need for competent knowledge and sound advice concerning the manifold influences of normal communication skills on personality growth.

The book literally teems with ideas and suggestions for research and conceptual synthesis. Its overwhelming stress is on correction rather than prevention.

It is to be wondered if continued systematic surveys of the incidence of severe speech defects in young children might not lead to the discovery that some are caused by events analogous to those of blindness in retrolental fibroplasia.—JOSEPH F. JASTAK, PH.D., Wilmington.

## TEXTBOOK OF PSYCHIATRIC NURSING

By Arthur P. Noyes, Edith M. Haydon  
and Mildred van Sickle

*New York, Macmillan Company, 1957. 415 pp.*

Previously, the nurse-patient relationship has been handled as a separate and distinct

part of nursing technique. This text introduces this relationship at the beginning and elaborates on it as the opportunity arises. This development of the nurse-patient relationship clarifies the nurse's role toward the patient while the text explains the diagnostic categories of psychoses and neuroses. It would seem a logical and simple blending of the two subjects.

This text should be most useful to professional students and to graduate nurses for both review and clinical teaching purposes. The terminology used would also make it beneficial to practical nurse students either as a text or as a reference source.

It seems to this reviewer that the text has unlimited use and value to any nurse or student nurse whether she is currently engaged in psychiatric nursing or in general nursing duties, since the nurse-patient relationship exists in all phases of nursing.

Although the nurse-patient relationship, as well as definitions of psychological behavior patterns, are traditionally taught during the psychiatric affiliations, these two phases in the development of students have wider application in the general work role of the nurse.—MRS. MARGARET MARSHALL, R.N., Essex County Overbrook Hospital, Cedar Grove, N. J.

## THE DOCTOR, HIS PATIENT AND THE ILLNESS

By Michael Balint

*New York, International Universities Press, 1957.*

This is an important book and should receive attention from both general practitioners and psychiatrists. There is need for serious consideration of the role of the family doctor and the part he plays in the handling of illness. It is perhaps one of

the most urgent problems in the practice of medicine.

This book represents the results of a research project sponsored by the Tavistock Clinic of London. Headed by Dr. Michael Balint and Enid Balint, 14 general practitioners took part in the team approach. In the words of Dr. Balint, "Our chief aim was a reasonably thorough examination of the ever-changing doctor-patient relationship, *i.e.*, the study of the pharmacology of the drug 'doctor'."

The book is divided into three parts. The first nine chapters are chiefly concerned with a critical analysis of the problems to demonstrate what aspects are in need of revision. The next five chapters deal with the subject of psychotherapy by general practitioners. The final six chapters are more general, more reflective and inferential.

There have been minor attempts in this country to explore, with general practitioners, the area covered by this book. They have usually been short-term projects, highly didactic, more closely related to teaching and assuming that "the answers are known; it only remains to teach it to the needy." Dr. Balint's approach is different. He has projected a vast unknown area to be explored jointly by psychiatrist and practitioner on a long-term (2 or 3 years) continuing basis. Out of this project many new bits of learning have emerged. How to formulate them so that the reader may profit is in itself a research project of writing which Dr. Balint has carried through successfully.

This book should be widely read and discussed. If it receives the attention it deserves, it will likely be stimulating to small group projects of a similar pattern throughout this country.

Our #1 need in medical practice today is to assist the general practitioner in the

handling of illness which is partly or wholly of psychogenic origin. It is likely that 50% of his patients are in this category, yet he has been taught nothing in most medical schools as to the treatment of this group. Dr. Balint's book is a large step toward an honest approach to this problem.  
—LEWIS H. LOESER, M.D., Newark, N. J.

## PRESERVATION OF YOUTH

Essays on health translated by H. L. Gordon from the original Arabic (*Fi Tadbir As-sihha*)

By Moses Ben-Maimon (Maimonides)

New York, Philosophical Library, 1958. 92 pp.

This monograph, which could be more aptly titled *The Preservation of Health*, was written in Arabic in 1198.

The author for the most part follows the ancient medical tradition of Galen. He places great emphasis on the type of food eaten—noodles, pancakes, peaches and apricots are very bad, rabbit's brain is good for head noises, the flesh of the wild ass strengthens vision, etc. The type of air breathed is also of great importance. He advocates suburban living with a northeast exposure and advises keeping pigeons in the house, since their aroma prevents neurological disorders. Bathing according to an elaborate ritual is healthful; one should always wash the head in the hottest water that can be tolerated, which hardens the substance of the brain. Extreme sexual abstemiousness is advised; "whoever wishes to remain healthy should chase the idea of intercourse from his mind as much as he can." He considers soft stools the foundation of health.

The great medical philosopher of the Middle Ages does have some very wise

things to say. He insists that no physician is better than an unskillful one, who is likely to thwart nature in its efforts to heal. He opposes phlebotomy and drastic purging except in rare cases. He says that one should employ attendants for the sick who can cheer the patient, tell gay stories and play musical instruments. He believes that emotional experiences cause marked changes in the body and its reactions. Strong self-discipline and a philosophical attitude toward life bring an equanimity which greatly contributes to health. "Mourning and sorrow over things that have passed are the activities of those who lack intellect."

This little volume gives a vivid picture of the best in medical practice during the Middle Ages.—MANFRED S. GUTTMACHER, M.D., Baltimore.

# PERSONAL ADJUSTMENT; AN APPROACH THROUGH THE STUDY OF HEALTHY PERSONALITY

By Sidney M. Jourard, Ph.D.

*New York, Macmillan Company, 1958. 462 pp.*

Can one help personal adjustment through the study of the healthy personality? Most readers will remain unconvinced.

Furthermore, this volume does not advance the previous valuable contributions made to positive mental health. For these I refer the reader to George S. Stevenson, Abram Blau, Dorothy Conrad and many others. No matter how just may be the criticism of the physician's approach to personal adjustment as being weighed too heavily in the interest of pathology, it never excuses naïveté and the substitution of "faith" for science.

In any case the realization by Freud and others that the pathological illuminates its

biological matrix has been most productive. So much so that accurate knowledge of the psychoanalytic approach has almost become a prerequisite before new formulations can be assured of successful application in our field. Nor does substituting other words for psychoanalytic concepts always result in clarification. For example, drives are called needs; denial, perceptual defense; isolation, verbal reformulation. "Objects" to me is still more accurate than "need objects." "Wants" is more descriptive than "need tensions." Furthermore, advice is presumptuous; at least it is awkward. In my opinion the author's advice to bored married couples or sexually frightened students may be misleading.

The thinking of Maslow, Sullivan and Fromm on the healthy personality constitutes a more solid part of the book. Most readers will agree that a self concept based on the real self, a feasible self ideal and an accurate public self indicates health. It may be a while, however, before many of us can make much practical use of these formulations as aids in personal adjustment.—DONALD A. SHASKAN, M.D., San Francisco.

## ZEN FLESH—ZEN BONES

A collection of Zen and pre-Zen writings

Paul Reps, comp.

*Rutland, Vt., Charles E. Tuttle Co., 1958. 211 pp.*

*Zen Flesh—Zen Bones*—essentially a collection of Zen stories—proffers neither pleasure nor profit to anyone who is not already informed in Zen Buddhism. Taken literally, the text reads like the tales of a simpleton: "A Monk asked Toshu, a Chinese master: 'Has a dog Buddha-nature or not?' Toshu answered: 'Nul'" "A Monk asked Baso: 'What is Buddha?' Baso said: "This mind is not Buddha.'" No after-dinner



anecdotes therel Nor enlightenment either—unless, of course, one had already fathomed the “meaning” of Zen.

Zen is the most precious distillate of the teachings of Buddha, “the most remarkable (of the) spiritual possessions bequeathed to Eastern people” (Suzuki). But Zen Buddhism is not to be fathomed save by dint of much study.

Since this is a review of the book and not of Zen, I can do no more than to counsel those interested to read Suzuki’s work on Zen—Jung’s introduction is most helpful—and revert to the work under review. It embodies 101 Zen stories: *The Gateless Gate* of Ekō; *Ten Bulls* by Kakuan; and *Centering*—transcribed by Paul Reps.

There is no describing the content of the work. The tales are somewhat reminiscent of Chassidic stories, but they differ in this essential respect: the latter nearly always bear a moral. The Zen collection bears none, save only perhaps “the lesson of Nothingness,” or, to paraphrase it in the less unfamiliar language of the western mystic (Chassidic and Christian) “how to tap the Fluidium of Eternity.”

The book itself is beautifully made. It is illustrated with a number of superb drawings reproduced as woodcuts, made by the 12th century Chinese master, Kakuan.

This is a work to be owned and treasured. Who knows but it may by some sympathetic magic entice one to taste more of the heady wine of Zen Buddhism?—IAGO GALDSTON, M.D., New York Academy of Medicine.

## CRIME AND INSANITY

Richard W. Nice, ed.

*New York, Philosophical Library, 1958. 280 pp.*

This book is described as the product of a symposium by 12 experts in jurisprudence, psychology, psychiatry, sociology and educa-

tion; it deals with the problems of the mentally ill who are accused of crime. It contains also an appendix summarizing replies to questionnaires sent to correctional, mental health and judicial leaders of the 48 states and the District of Columbia. Six questions were asked about state laws dealing with insanity as a defense to crime. The editor holds degrees in both social work and psychology and currently is working toward his Ph.D. in psychology at Arizona State College.

Several of the contributors, including Dr. Henry Davidson, Dr. William Haines, Simon Sobeloff, Prof. Henry Weihofen and Prof. Herbert Wechsler, present material similar to, if not identical with, material that they have previously published elsewhere. Dr. Davidson reports on the topic of irresistible impulse. Dr. Haines and John Zeidler summarize laws in various states dealing with insanity as a defense to crime. Mr. Sobeloff’s article “From McNaghten to Durham and Beyond” duplicates a lecture that he delivered in May 1955 before the National Conference of Bar Councils. Prof. Ralph Winn, Prof. Donald R. Cressey and Prof. Herbert A. Bloch present philosophical discussions with reference to principles of punishment and describe differences in viewpoints among lawyers, sociologists and psychiatrists.

One chapter, by William F. Burke, Jr., entitled “New Light on the Eternal Conflict Between Law and Medicine in Judicial Practice” will be discussed in more detail inasmuch as the content of this chapter is quite different in tone and content from the rest of the book. Mr. Burke is described as the founder of the National Psychiatric Reform Institute in Albany, N. Y. On page 128 Mr. Burke writes, “In this enlightened day and age, patients, sad to say, are still being fraudulently committed in wholesale numbers to mental hospitals—where they

do not belong." In discussing the use of electroshock therapy for the treatment of patients with mental illness, he writes on page 130, "The human brain is the center of the nervous system, the seat of consciousness and volition. It is for this reason that the mentally ill person himself, if he is at all rational, should be permitted to sign for or refuse to submit to shock treatment." On the same and following pages he writes, "Operations without permission should be outlawed, and patients suffering from syphilis should not be forced to submit to spinal taps, because such spinal taps often injure the patient, causing him to become a paresis case years before he would have if the disease were allowed to take its normal course."

This reviewer challenges such statements and wonders if Mr. Burke could document his material.

The book contains many errors. The name of Judge David Bazelon is repeatedly misspelled as Bazelo. Incorrect listings of footnotes are made. In Dr. Davidson's chapter a statement is made that there are 12 states where irresistible impulses are defense to crime; in the footnotes only 11 states are mentioned; in Appendix II, on page 258, the statement is made that the irresistible impulse test exists in 14 states, in courts of federal jurisdiction and in the United States Army and that, in addition, another state has the delusional impulse test.

For those who are interested in this general subject and who have not read much of the literature, this book has some value inasmuch as it describes current attitudes of persons of different disciplines toward this controversial subject. It describes recent changes in laws in some jurisdictions and contains one chapter by Prof. Herbert Wechsler with reference to a proposed model penal code prepared by the American Law Institute.

In summary, this reviewer believes that this book has some merit for the reader who is interested in this general topic but who is not well versed in recent literature. The book, however, contains many errors which might be accepted as facts by the unsophisticated reader.—FRANK J. CURRAN, M.D., Children's Service Center, Charlottesville.

## THE SCIENTIFIC STUDY OF SOCIAL BEHAVIOR

By Michael Argyle

*New York, Philosophical Library, 1957. 239 pp.*

This scholarly book, which summarizes and compares several hundred studies (a bibliography of 25 pages) of social behavior consists of two main parts: one on methodology, the other on generalizations and theories. The author is a lecturer in social psychology at Oxford University. The chief focus is on interaction between pairs of people, behavior in small social groups and human relations in industry. The emphasis is on the study of social interaction excluding personality and socialization. In general, theory is eschewed and an empirical point of view prevails—facts are put before theory.

The broad title of the book is inviting but leads to two important questions: What constitutes a "scientific" study? And what should "social behavior" include? The author's concept of science is clearly stated (p. 6): "The scientific approach consists in the first place in establishing empirical generalizations about the relations between a number of *measurable* (reviewer's italics) variables." He stresses that no valid conclusions can be drawn in the social sciences without statistical methods. In discussing the use of the "human instrument" (p. 31), the author says, "The human instrument

can be examined in exactly the same way as any other measuring device." Thus the author's conception of science is rather narrow, constricted, quantitative and dependent upon the measurability of a proposition. Concepts which may be tested and verified, even though not measurable, can be scientific if one believes in a broader range of science.

In a similar manner, consideration only of those aspects of social behavior which can be envisaged as measurable variables eliminates many vital aspects of social behavior. There is no doubt that one obtains a broad survey of the complex field of social behavior which lends itself to numerical considerations. However, one is left with doubts as to the meaningfulness of the material presented in its relation to the basic understanding of social behavior. The clinician (social worker, clinical psychologist, psychiatrist, etc.) may benefit from learning about methodology and techniques of measurement but would have difficulty in reconciling this type of data with the experience of dealing with human beings, individually and socially. Reversing the statement, can one anticipate that the author would learn about human behavior from the clinician, especially with his adoption of a restricted philosophy of science? The basic model of experimental psychology utilized by the author has not proved fruitful in the past for social workers, clinical psychologists and psychiatrists.

Even though the author avoids theory, his approach represents a specific theoretical position in his attitude toward facts. One might ask again: How do we agree as to what are the significant and relevant facts of social behavior which should be tested or measured if possible? The clinician is confronted with a difficult methodological problem when trying to do research in psychotherapy or in the field of social behavior.

In psychotherapy or in psychoanalysis the treatment is a research process at the same time that it is a therapeutic process. Especially in psychoanalysis is there such an intimate interweaving of theory and practice. As far as the social sciences are concerned, what is lacking is a theory of personality. E. Shils in *The Present State of American Sociology*<sup>1</sup> clearly demonstrated the need for the sociologist to develop a satisfactory theory of personality.—JOSEPH J. MICHAELS, M.D., Belmont, Mass.

### STUTTERING IN CHILDREN AND ADULTS

Thirty Years of Research  
at the University of Iowa

Wendell Johnson, ed.

Minneapolis, University of Minnesota Press, 1955.  
472 pp.

The speech clinic of the University of Iowa is one of the oldest centers of research and treatment in its field and many of the leaders in speech therapy and workers in schools and clinics have been trained there. The results of 30 years of continuous research in stuttering, from 1924 to 1955, as well as the points of view of those in charge of it are therefore of major importance.

A bibliography of University of Iowa Studies of Stuttering through 1954 forming the appendix of this volume lists 266 publications and 153 graduate theses. The book contains 42 previously unpublished papers, most of which are short condensations of M.A. or Ph.D. dissertations. Notable exceptions are Johnson's "A Study of the Onset and Development of Stuttering" and Frederic L. Darley's "The Relationship

<sup>1</sup> Glencoe, Ill., Free Press, 1948.



of Parental Attitudes and Adjustments to the Development of Stuttering," which are published in full, and "Studies of Non-fluency in the Speech of Preschool Children" by Margaret E. Branscomb, Jeannette Hughes and Eloise Tupper Oxtoby, which is a condensation and coordination of three dissertations.

The editor devotes the first chapter of the book to a review of the part played by various persons, chiefly Dean Carl E. Seashore and his associates, in the early planning and development of the program, and to a more detailed commentary on the changing focus of interest as the years passed. The chapter constitutes the editor's own evaluation of the studies, most of which he directed, and it seems appropriate to follow his lead in reviewing the book.

The "dominance" theory of Samuel T. Orton, elaborated by Lee Edward Travis, first director of the Iowa Speech Clinic, motivated "most of the studies from the mid-twenties to the mid-thirties and many of those completed later . . . Prolonged and intensive investigation," says Johnson, "failed, so far as I can judge, to turn up any distinctive physical differences between stutters and nonstutters."

Gradually, by the mid-thirties, attention was directed to other approaches. Personality studies indicated that stutters are essentially like nonstutters and that their tendencies to be "a little more socially withdrawing and a little more inclined toward discouragement" are normal reactions "to the frustration and humiliation of stuttering."

The need for normative data on speech fluency in children led to investigations of childhood speech, the onset of stuttering and the relation of parental attitudes and adjustments to the development of stuttering. These studies "yielded substantial indications that the children who develop

stuttering are essentially normal," but that the parent or other listener decides that the child's speech is not as it should be and expresses his judgments "in postures, frowns, or even actual statements that the child interprets as disapproval . . . What it comes to, so far as I can determine, is that the speaker (the child) responds to what the listener (the adult) does. And what the listener does seems to be more or less unnerving to the speaker, so that, while the responses and effects appear to be quite subtle and slow-working in most cases, the speaker's reactions to the listener's evident evaluations come in time to be marked by noticeable hesitation and tension. And as this development leads to more evident concern and disapproval on the part of the listener, so this more evident concern and disapproval are reacted to by the child with speech attempts that are correspondingly more unsure and strained. It is a vicious cycle, and, as such, it tends to expand."

Observation of the variability of stuttering in relation to "environmental" and "psychological" factors led Johnson to believe that the problem "might be approached by concentrating on the *moment of stuttering*." Many studies followed which attempted to measure the frequency and the amount of stuttering by counting the moments of stuttering "in systematically obtained samples of speech."

Condensations of 15 of these studies make up Part IV of the book, covering 111 pages. They revealed the following basic phenomena: 1. the adaptation effect (the decrease in stuttering as measured with reference to its frequency or severity, that occurs when a stutterer reads the same passage a number of times consecutively); 2. the consistency effect (the tendency for stuttering to occur consistently in response to the same cues or stimuli); and 3. the spontaneous recovery of the strength of the stuttering re-

sponse (as measured with reference to its frequency or severity) subsequent to a sufficient interval of time following adaptation.

It is noteworthy (and the editor does note) that "the condition under which the data being discussed were obtained was that of oral reading in a laboratory situation" where, he says, less stuttering occurs and where the adaptation and recovery effects are more pronounced than during "so-called spontaneous or propositional speech."

Johnson concludes the chapter with a tentative theory of stuttering. He says: "At the present stage of the total research program, if we take into account not only the available data on adaptation, consistency, and spontaneous recovery, but also all the other findings reported to date, and the hypothesis already stated with respect to the onset of stuttering, a relatively rough theory may be attempted . . . Stuttering appears to be an anxiety-motivated avoidant response that becomes 'conditioned' to the cues or stimuli associated with its occurrences . . . This anxious or apprehensive expectation comes to be associated with and to be elicited by sounds, words, listeners, and other cues or features of situations in relation to which stuttering has been experienced in the past. Such cues, then, function as reminders, and so as 'storm signals' warning of 'danger ahead' . . . Stuttering, then, is what the speaker does trying to keep from stuttering—again . . . As the anxiety about stuttering is weakened, therefore, both the frequency and severity of the avoidant reactions—of the stuttering, that is—are reduced. Improvement is a function, then, of anxiety deconfirmation."

This observation comes at the end of the editor's review of the total stuttering research program at Iowa. One therefore might be led to believe that his theory of stuttering is based entirely on the results of that program. Such a conclusion, however,

would ignore the fact that nowhere in the book is there a study of anxiety, motivation or anxiety-motivation alone or in relation to stuttering. The theory therefore appears to be based largely upon all the other findings reported to date and upon the author's hypothesis with respect to the onset of stuttering. This in no way detracts from the theory, but rather illustrates its author's breadth of vision and understanding.

The book offers much that is of value in addition to the story of the development of research in stuttering at Iowa. The condensed experimental studies reveal many facts not available elsewhere, and the three longer studies are a real contribution to the understanding of stuttering.—FREDERICK W. BROWN, Sewanhaka High School, Floral Park, N. Y.

#### FREE TIME: CHALLENGE TO LATER MATURITY

By Wilma Donahue, Woodrow W. Hunter,  
Dorothy H. Coons and Helen K. Maurice

*Ann Arbor, University of Michigan Press, 1958. 172  
pp.*

While the two topics—the use of leisure time and the years of late maturity—are receiving increasing amounts of attention, they are still highly neglected interests. Our culture seems to cling to the idea that we are a "young" country with problems largely of youth and middle age, although reality dictates otherwise. The entire problem of free time and the later years is sharpened more clearly by twin facts—a lengthened life span and an earlier retirement.

About a century ago the individual worked 70 hours a week and the average life expectancy was around 40 years. Today the reverse is true. We have a 40-hour

week and a 70-year life expectancy with increasing amounts of leisure time on our hands.

This book tells how to employ one's free time with maximum benefits to the individual and to society. The highly competent authors indicate the importance of the joys gained from the use of one's faculties in creative expression and group endeavor.

*Free Time: Challenge to Later Maturity* contains discussions by sociologists, economists, educators, psychologists and physicians on how to prepare for the leisure of the later years. Psychological factors involved are evaluated and practical plans for creative endeavor are discussed. It is a valuable source book for planners as well as for intelligent laymen.—ARTHUR LERNER, Los Angeles City College.

## PSYCHIATRIC INPATIENT TREATMENT OF CHILDREN

J. Franklin Robinson, M.D., ed.

Washington, American Psychiatric Association, 1957.  
194 pp.

There is a spreading aura of optimism regarding the therapeutic management of severely disordered children who previously had been considered hopeless. Such children constitute catastrophic burdens to their families and to the community. Even now, treatment resources for these children are demonstrating the possibilities of extending the bounds of treatability. On the other hand, the current mushrooming of inpatient facilities for children before the establishment of suitable standards has engendered considerable confusion. The confusion has been increased further by the multiplicity of auspices which range from

medical to social service to educational. In many cases the phrase "residential treatment" has even acted as a euphemistic façade for outdated placement facilities for dependent children. The 1956 conference on inpatient treatment for children was therefore very timely indeed. The report based on the conference proceedings should be read by all workers with children.

In view of the present uncertainty regarding treatment responsibility, the conference recommended that children's inpatient psychiatric treatment centers be called hospitals. An inpatient psychiatric treatment service—a psychiatric hospital for children—is defined as "a medical facility established for the diagnosis and treatment of children suffering from psychiatric disorders, in which the psychiatrist carried medical and corresponding legal responsibility for the diagnosis and treatment of the patient. It may be an independent institution or an identifiable medical unit in a medical or nonmedical agency."

With this general definition in mind, the conference focused on all major questions which need to be answered by those who plan for inpatient treatment of children. It considered such practical problems as architectural design, cost planning, staff selection, staff training, evaluation and research.

Most important, perhaps, the participants agreed on a general orientation to treatment. Treatment was viewed as the global impact of a child-centered atmosphere, where each child is offered a design for living which uniquely enhances his feelings of safety and his capacity for growth and self-regulation. In this regard the trend is toward community-rooted residential units with provision for adequate parental and community participation. Similarly, although it was recognized that the pressure for service to children is very great, opinion



tended to favor small open units which could permit meaningful and helpful interaction between adults and children.

All agreed that careful day-to-day programming, individualized education and warm, thoughtful child care by supervised and trained adults are the cornerstone of treatment. Within this kind of individualized climate, therapeutic procedure such as direct psychotherapy and drug therapy can

be applied with appropriate perspective and maximal effectiveness. The modern point of view rejects the disorder and ignorance of mass custodial care of disturbed children. Apparently, too, child psychiatry now possesses a point of view and concrete tools for building adaptive equipment in ego-deficient children.—WILLIAM GOLDFARB, M.D., Henry Ittleson Center for Child Research, New York City.

# Notes and Comments

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Arthur S. Flemming, Secretary of Health, Education and Welfare, launched the national observance of Mental Health Week April 26 with the ringing of the historic Mental Health Bell at St. Elizabeths Hospital, federal mental hospital in Washington, D. C.

The 300-pound bell, symbol of the mental health movement, was cast in 1953 from chains and handcuffs formerly used to restrain mental patients. It is rung each year to start Mental Health Week.

Before the ceremony, Secretary Flemming, his family and other guests attended a religious service in the hospital chapel, together with several hundred mental patients. The Reverend Ernest E. Bruder, a hospital chaplain, preached a special Mental Health Week sermon.

The bell-ringing ceremony also signaled the beginning of Operation Friendship, nationwide Mental Health Week project aimed at bringing 750,000 visitors to mental hospitals across the country—as many visitors as there are patients. In many states and hundreds of localities, governors and mayors and their families were in the first contingent of hospital visitors.

Joining Secretary Flemming in ringing the Mental Health Bell were 4-year-old Mary Cornelia Link, of New York, the little girl pictured in the official Mental Health Week poster, several patients from St. Elizabeths, and the hospital director, Dr. Winfred Overholser. Also attending were Judge Luther Alverson of Atlanta, president of the National Association for Mental Health, and Dr. Robert H. Felix, director of the National Institute of Mental Health.

Judge Alverson said 800 state and local NAMH affiliates were joined in Operation Friendship by thousands of local affiliates of other national organizations in "what is probably the largest joint national venture

ever undertaken by health and welfare organizations in this country's history." National organizations participating have a total membership in excess of 50,000,000.

Throughout the country the project had considerable impact. In Illinois, for example, an unprecedented 75,379 citizens visited the 12 mental hospitals and two schools for the mentally retarded during Mental Health Week. In New York City, the *New York Times* commended NAMH and Operation Friendship in a Sunday editorial beginning "The open-door policy at mental hospitals works best when the door opens both ways." In Pittsburgh, visits to Mayview Hospital were conducted by KDKA, a radio station of the Westinghouse Broadcasting Company, as part of the network's year-round campaign to promote better mental health.

In the words of those who evaluated the results of the project in Alabama: "Operation Friendship has offered an unusual opportunity in the mental health movement to dramatize and publicize the needs of mental patients and the goals of mental health associations everywhere. It has forcefully brought to the attention of the public that Mental Health is on the move and has focused that motion toward mental hospital patients.

"The direct results of Operation Friendship are visible, successful and therefore rewarding. It is safe to assume that this project has won new interest in mental health, increased awareness of the problems of mental illness, and new friends for the entire movement through the intensive public information campaign that led up to and accompanied Operation Friendship."

## RESEARCH

The first grants made by the National Association for Mental Health under the

association's new research program were announced last month by Dr. William Malamud, director.

The grants were made to seven research scientists by the NAMH research committee at a meeting April 6. The scientists, the titles of their projects and the amounts of the grants follow:

- Dr. Ernst Prelinger, Yale University, \$2,000 for a study of character structure and related ego functions.
- Dr. John I. Nurnberger, Indiana University Medical Center, \$5,000 for a study of the effect of a special environment on psychotic (schizophrenic) children.
- Dr. James Maas, University of Cincinnati, \$1,100 for a study of the relationship of free anxiety vs. the "schizophrenic process" to alterations in biochemical measures.
- Dr. Eugene Roberts, City of Hope Medical Center, \$9,000 for a study of physiological and biochemical correlations of the role of gamma-aminobutyric acid in the central nervous system.
- Dr. William G. Clark, University of California Medical Center, \$8,000 for a study of adrenergic transmitters and modulators.
- Dr. J. S. Gottlieb, Lafayette Clinic, Detroit, \$10,000 to continue a study of intermediary carbohydrate metabolism in schizophrenia.
- Dr. Theodore X. Barber, Worcester Foundation for Experimental Biology, Shrewsbury, Mass., \$13,639 for a study of hallucinatory behavior in schizophrenics and normals.

The NAMH research department has received 35 applications for grants totaling about \$400,000. The committee expects to act on some of these at a meeting in June.

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Two research projects to reduce the number of inpatients admitted to mental hospitals, involving the use of psychiatric home treatment and a study of alternatives to hospitalization for geriatric patients, are now underway at the Boston University School of Medicine and Boston State Hospital.

Both programs are supported by grants from the U. S. Department of Health, Education and Welfare. They are under the direction of Dr. Walter E. Barton, associate professor of psychiatry and superintendent of the hospital.

The home care study at Boston State Hospital is the first such project in the United States. Similar experiments have proved successful in England and Holland, where home care has been practiced for over 25 years. According to Dr. Barton, this offers the first hope that mental hospitals can cut down their admission rate.

Two teams, each consisting of a doctor, a psychiatric social worker and a psychiatric nurse, are now working in the Dorchester area of Boston, a community of 100,000 residents belonging predominately to the middle- and lower-income classes, with mixed ethnic and religious backgrounds. The doctors use psychotherapy as their primary tool, as they would if they were seeing patients in their office or in an out patients clinic.

The geriatric project is being carried out in two stages. The first, now in progress, involves extensive interviews of 75 geriatric patients admitted to the hospital, their families, friends and associates, to get as complete a picture as possible of the needs of older people, where in their lives they failed to provide for these needs, and what can be done to maintain them in their home surroundings. In the second step the data will be analyzed to see what types of community resources are needed to allow these



people to remain in their home communities, instead of admitting them to mental hospitals.

Both projects require extensive work outside the hospital. When the home care program came into existence, the researchers saturated the community with information about the project. They personally told each community agency, doctor, clergyman, police surgeon and others that the home care service could be called when hospitalization was needed. In this way they are able to keep track of every patient in the Dorchester area who requires institutional care.

In the geriatric program, spot checks will be made of geriatric admissions to general hospitals, nursing homes and clinics. If the check shows a different pattern from the survey of Boston State Hospital patients, it will be pursued until proved statistically significant.

When the home care service is called, there are two alternatives. Either a doctor and a social worker go directly to the home or the psychiatric nurse goes, observes and then calls the doctor to report her observations. When both the doctor and the social worker go, the social worker deals with the patient's family and their problems while the doctor talks to the patient.

If the doctor feels additional care is needed, he will recommend it to the patient, making the widest possible use of community resources such as drug therapy administered by the family physician or referral to a clinic. In each case, the doctor makes at least one visit to the patient's home; the average is 4 to 6, and one patient was visited 44 times.

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A state-by-state study of mental health research in the South has been launched by the mental health program of the Southern

Regional Education Board, according to Dr. William P. Hurder, director of the program and the study.

The study is designed to get detailed information about the South's resources and needs in research on mental health and behavioral science, including mental retardation. It will also provide a reliable estimate of research projects in progress and how they are being carried out.

Over 2,000 questionnaires have been distributed to research personnel and administrators throughout the region with the cooperation of a committee of research survey chairmen appointed by the governor of each participating state. Analysis of the completed questionnaires is already in progress. The results of the study will be made available through publications and will also be presented at a meeting of educators, legislators and researchers in the fall.

The cooperation of the Bio-Sciences Information Exchange and the Council of State Governments will supplement the study findings and broaden the scope of the data gathered. The exchange is supplying information about current research activities (in the region and the nation) supported by national granting agencies. It is also making its services available for recording and analyzing data on research in progress which come out of the SREB study. The Council of State Governments will provide data it has collected from the 48 states on methods of organizing and financing state-supported research in mental health and related areas.

Referring to the need for this type of study, Dr. Hurder cited a remark by Admiral Hyman G. Rickover pointing out that the home permanent wave industry budgets for research into ways of improving the looks of human hair a sum amounting to 2¢ per female in the U. S. The whole nation, meanwhile, spends only 3¢ per capita

for research into what goes on inside the head.

The regional mental health program was established in 1954 by the SREB at the request of the Southern Governors' Conference and is supported by an appropriation of \$8,000 from each participating state. Its purpose is to aid states and Southern colleges and universities to train more qualified personnel for mental health programs and to aid in securing added support for needed research programs.

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Dr. William Malamud, director of research for the National Association for Mental Health, gave the first of a series of lectures honoring Dr. David C. Wilson, retired chairman of the psychiatry department at the University of Virginia School of Medicine. The association's new research program was one of the topics covered in his discussion of current research in psychiatry.

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A major discovery in the treatment of cretinism has been reported by doctors at the University of Michigan Medical Center. For the first time in medical history they have counteracted the dread disease by treating the patient before birth.

The work thus far has been on a limited scale, but the doctors have successfully stopped cretinism in one child. The treatment has had no ill effects either on mothers or their children.

Cretinism is a congenital disorder caused by improper functioning of the thyroid gland. It produces irreparable damage to the brain, physical deformity and idiocy.

A medical research team headed by Dr. Edward A. Carr and Dr. William H. Beierwaltes conducted extensive studies of the disease before applying their findings to the correction of the disorder. They determined that any cure for cretinism would

have to be started before the patient was born. Once the child is born most of the damage has already taken place.

Two supporting discoveries led to finding the successful treatment, Dr. Beierwaltes said. One was a statistical finding that a woman who gave birth to two cretins had a very great chance of producing a cretin in her next pregnancy. The second came from work with animals. The scientists discovered that strong doses of thyroid extract given to mothers during pregnancy would be transmitted to the fetus.

Ready to test their work on humans, they found two women who, statistically, were likely to give birth to cretins. The women were given massive doses of thyroid extract—seven times the normal daily dosage prescribed for underactive thyroid glands—throughout the remainder of their pregnancies. Both delivered non-cretinous children. One child, they found subsequently, had no thyroid gland. He definitely would have been a cretin if the treatment had failed.

Dr. Beierwaltes said the next stage in their study will be to seek a method for diagnosing cretinism in advance in a couple's first child. At present they can predict it only on the basis of two previous cretins.

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A composite list of 137 research studies on psychopharmacologic drugs being conducted under support of grants from the National Institute of Mental Health is now available.

As classified by the institute's Psychopharmacology Service Center, the studies fall into three main categories: 57 studies directly related to problems of drug development and assessment; 68 studies of the basic mechanisms of the action of psychopharmacological agents; 12 studies pertain-

ing to method development and data analysis.

The drug development studies include research related to synthesis of new drugs, screening of drugs in animals and normal subjects, early clinical screening, and controlled clinical trials on patients with schizophrenia, depressions or neurotic conditions.

Single copies of the list of research grants, divided by category and including the name of each investigator, his institution and a brief description of his project, are available on request from NIMH, Bethesda 14, Md.

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The National Committee on the Aging announced in April that it had received an \$18,000 grant to conduct a study of dependency and guardianship of older people. The grant was made by the Frederick and Amelia Schimper Foundation of New York.

The committee decided to make the study after surveys revealed many older people could not handle their own affairs, financial and otherwise, because of mental or physical deterioration. A number of agencies, including the Bureau of Old Age and Survivors Insurance and the Bureau of Public Assistance have in recent years requested the National Committee on the Aging to make a study of this problem.

The committee, a nonprofit national resource for planning, information and consultation on aging, is a standing committee of the National Social Welfare Assembly.

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In the next five years the Rockefeller Foundation will contribute \$41,000 toward biochemical research on mental disease at Oxford University. This will assist further exploration of a theory that mental disease, particularly schizophrenia, may be related to abnormal chemical factors. Partition

chromatography—a method of isolating single chemical compounds from mixtures—will be used to analyze the body fluids of schizophrenics and of a control group.

\* \* \*

A chromosome count of 47 has been found in six typical mongoloids by a research team headed by Patricia Jacobs at Edinburgh's Western General Hospital. "It appears," the scientists note, "that the condition of mongolism is associated with the presence of an extra chromosome."

Among the many implications of their findings is "the association of a predisposition to leukemia in a group of individuals with an abnormal karyotype which is clearly of great interest and potential importance. The significance of this association in relation to possible mechanisms of carcinogenesis remains to be elucidated," the researchers add.

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Two studies of the effect of special day training classes for children who are severely retarded mentally are being carried on with federal funds approved by U. S. Commissioner of Education Lawrence G. Derthick.

A 5-year study by the University of Illinois will compare the performance of retarded children in a special class with that of other children similarly retarded in regular school classes. All will be 6-year-old first graders. Their performance will be rated for four years.

A 2-year study is also going on at San Francisco State College.

## LEGISLATION

Paul Johnston of Birmingham, a member of the legislative committee of the National Association for Mental Health, was to testify May 28 before the Senate subcommittee on appropriations for labor, health, educa-



tion and welfare, in support of a \$74,000,000 budget for the National Institute of Mental Health.

Speaking for the association he planned to present to this committee, chaired by Sen. Lister Hill of Alabama, many of the same facts he presented April 16 before the House subcommittee on appropriations.

Subsequently, on April 30, the House approved, without dissent, a budget of \$60,409,000 for NIMH—\$8,025,000 more than was recommended by the administration but \$14,000,000 less than NAMH and the American Psychiatric Association recommend. The House also accepted the NAMH recommendation that funds for the construction of research facilities be increased from \$20,000,000 to \$30,000,000.

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Gov. Robert B. Meyner of New Jersey asked the state legislature for \$30,583,445 for mental health—less than the \$32,543,582 recommended by the State Department of Institutions and Agencies, still less than the \$34,211,086 requested by the five state hospitals, but a little more than last year's \$29,608,442.

At present New Jersey's state mental hospitals have \$4.83 a day for each patient—compared to the \$11.43 spent by the Veterans Administration hospital at Lyons.

"This disparity results from public indifference, lack of information and lack of funds, which the New Jersey Association for Mental Health and its 15 county chapters are trying to overcome through public education," said Dr. Edward P. Duffy, Jr., president.

The association has pledged its support to state officials in the correction of deficiencies resulting in the loss of national accreditation by 4 of New Jersey's 5 state mental hospitals. Dr. Duffy said the association views the loss as a dramatic and timely illus-

tration of the need for more funds to provide more trained personnel to treat the 21,000 hospitalized mental patients.

Accreditation was lost by the Trenton, Marlboro and Greystone Park state hospitals and by the Neuropsychiatric Institute (Skillman). The fifth state hospital, Ancora, received only a 1-year approval.

A bill before the New Jersey legislature provides for reconstitution of the Commission on Mental Health.

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A brochure outlining Ohio's mental health needs was put in the hands of each member of the state's General Assembly by the Mental Health Federation, Inc.

The federation urged the legislators:

- To sign the Interstate Compact providing for the care and treatment of non-resident mental patients living in Ohio.
- To set up a separate State Department of Mental Health and a Bureau of Alcoholism.
- To provide more funds so that more patients could be treated by trained psychiatric personnel.
- To expand the state's mental health research program.
- To increase the number of mental health clinics.
- To provide funds for new treatments and rehabilitation services.
- To increase the state subsidy for community classes for the mentally retarded.
- To modify the laws governing state hospital admissions and the liability of patients (and their relatives) for the cost of treatment.

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Key members of the Connecticut Association for Mental Health pleaded for more funds for the state mental health depart-

ment at recent hearings before the appropriations committee of the legislature. The department is asking for \$58,900,000 but Gov. Abraham A. Ribicoff has recommended \$14,600,000 less—only \$44,300,000.

Association spokesmen say the Governor's figure "falls \$4,200,000 short of what is needed to stand still" (because of mandatory automatic cost and wage increases). Nor does the amount recommended by the Governor allow for the staffing of new buildings now being completed or for more personnel to treat more patients.

A bill before the House would provide state aid for vocational training centers for the mentally retarded. Another calls for a bond issue to acquire land for, construct and equip a mental health center in New Haven. In cooperation with the Yale Medical School, the center would provide diagnosis, treatment, research, out-patient service and part-time care for patients needing only day or night hospitalization.

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Gov. G. Mennen Williams of Michigan called for a mental health budget of \$69,401,693—an increase of \$4,234,943 over last year's.

He recommends \$60,639,093 for the State Department of Mental Health, \$6,612,600 for the hospitalization of patients in Wayne County, and \$2,150,000 for mental health services at the University of Michigan (including \$924,482 for the Neuropsychiatric Institute, \$1,165,929 for the Children's Hospital and \$365,790 for research).

The Michigan legislators are also considering adoption of the interstate compact on mental health, as well as a measure prescribing the civil rights of mental patients, outlining procedures for reimbursement of the costs of hospitalization in state institutions, and modernizing commitment procedures.

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Approval of a \$43,152,000 mental health budget by the Texas legislature would mean \$4.13 a day could be spent on the care and treatment of each patient—instead of the present \$3.40 average in the state's mental hospitals.

This amount—requested by the Board of State Hospitals and Special Schools and supported by the Texas Association for Mental Health—would allow for 34 more doctors, 500 more nurses and attendants, 11 more psychologists and 29 more social workers.

Funds are also asked for 5 regional mental health centers in 1959-60 and for 10 centers in 1960-61. They would offer diagnostic and treatment services for emotionally disturbed, mentally retarded and handicapped children, and counseling for their parents. Personnel at the centers would also diagnose and treat disturbed adults, discharged mental hospital patients and alcoholics.

Of Texas' 254 counties, only 8 have community mental health clinics. According to the Texas Association for Mental Health, only the 13 counties with populations over 100,000 are able to finance clinic services for themselves.

This legislature is also considering a bill which would permit participation in the interstate compact on mental health.

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"Brains before bricks" is the slogan in South Carolina, where the legislature is urged to provide funds for much-needed psychiatric personnel. A special legislative committee recommended the appropriation of \$400,000 for the expansion of psychiatric teaching facilities at the state medical college.

A concurrent resolution now under consideration would continue the work of a committee appointed to study the state's public and private mental health facilities and the laws relating to mental health.

This legislature is also considering ratification of the interstate compact on mental health.

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The Minnesota Association for Mental Health arranged for 21 members from 33 counties to testify before a state legislative committee on the need for a state appropriation of at least \$739,000 to match funds that they either have raised or expect to raise for community mental health centers.

Expansion of local psychiatric facilities is an important part of the state mental health association's 9-point legislative program.

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Nine specific recommendations were made to the Florida legislature by the state mental health association. They cover:

- \$1,000,000 for the construction of a much-needed 50-bed children's center on the grounds of South Florida State Hospital. There are 25 mentally ill children between 12 and 16 now on the wards with adults.
- \$160,000 for interim care for these children.
- \$4,173,000 to add 600 beds to the new 400-bed state hospital now nearing completion at Macclenny, near Jacksonville.
- \$1,237,000 for capital expenditures at the largest state hospital at Chattahoochee.
- \$465,000 for the Council on Training and Research in Mental Health, to be spent for staff specialists, research and scholarships.
- \$1,483,000 for the State Board of Health's bureau of mental health, a good part of this for more mental health workers in county health departments and child guidance clinics.
- Legislation authorizing a 2-year experimental program of foster home care for up to 300 aged men and women too infirm to be in their own homes but not requiring

nursing or hospital care. About 170 of them are in state mental hospitals and could be discharged at once if homes were available for them.

- Enough funds to increase the capacity of Sunland Training School in Lee County from 780 beds to 1,000.

- \$400,000 for additions to the school, an auditorium and recreation building, at Sunland Training Center in Gainesville, plus sufficient funds for additions to the hospital and staff residences.

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Gov. Robert T. Stafford and the Vermont legislature received requests totaling \$201,000 for mental health projects under the state's 2-year-old community mental health services law. The Vermont Association for Mental Health is urging the appropriation of at least this amount for the next biennium.

The association reports that Vermont lacks adequate clinics for its 7,000 emotionally ill children—about 8% of the school enrollment. There is also need for a psychiatric hospital unit for emotionally disturbed and mentally ill children requiring round-the-clock care.

The Vermont legislature is also considering a bill providing for the right of counsel for persons to be committed to mental hospitals.

A bill calling for ratification of the interstate compact is before the Vermont senate. Administration of the compact would be vested in the state commissioner of mental health.

Another measure would set up an Interdepartmental Board of Mental Health. The board would coordinate the mental health activities of 6 state departments—Health, Institutions, Social Welfare, Public Safety, Alcoholic Rehabilitation, and Education.



## CARE AND TREATMENT

Extensive psychiatric procedures are now covered by the New York State workmen's compensation fee schedule. A new schedule which went into effect March 1 calls for higher fees and increases payments for rehabilitation procedures.

Psychiatrists are now allowed \$25 for the initial interview, up to \$200 for shock therapy and up to \$225 for psychotherapy in the doctor's office or in a hospital. Under the old schedule they were paid only for the initial psychiatric interview, with the fee set at \$15.

Rehabilitation specialists will now be paid for such services as psychosocial determination, vocational guidance, daily activities testing and physical and occupational therapy. Under the old schedule they were allowed only \$25 for examination, observation and consultation.

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The National Institute of Mental Health reports that federal, state and local funds budgeted for community mental health services reached a new peak of \$64,800,000 in fiscal 1959, 20% more than in 1958.

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A unique "big brother" system is being used by hospitalized veterans in their fight against mental illness, the Veterans Administration has reported.

Recovering patients at the VA mental hospital in Salisbury, N. C., have formed a society known as "The Helping Hand," in which each member holds himself responsible for more seriously ill patients in hospital activities, the VA said.

Dr. Samuel J. Muirhead, manager of the hospital, said the scheme has proved an effective form of help for both its members and non-members. Improved patients can help less fortunate patients towards recovery in ways that the hospital staff cannot, he

said. Some patients, noting improvement in the condition of their companions, become aware that their own improvement is possible.

Membership in the society is restricted to patients approved by its screening committee and elected by unanimous vote.

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A day treatment unit for mentally ill children has been opened by the Henry Ittleson Center for Child Research in Riverdale, N. Y., in cooperation with the Interdepartmental Health Resources Board of New York.

The center now offers the seriously disturbed child and his family a comprehensive and flexible program of inpatient, outpatient and aftercare services, including individual and group therapy, education, psychological service, recreation and parent counseling.

The center accepts for treatment the seriously disordered child who has not been able to make a satisfactory adjustment in family life, school and community. Both boys and girls between 5½ and 8 years of age are accepted on a non-sectarian, interracial basis. Admission is not limited to any specific diagnostic classification, although children with obvious neurological deficits and with known mental deficiency and physical problems requiring special hospital care are not accepted.

A major criterion for admission is the availability and willingness of the parents to participate actively in the program.

Further information is available from Dr. William Goldfarb, director of the center, 5050 Iselin Ave., Riverdale 63, N. Y.

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The Office for Dependents' Medical Care of the U. S. Army has clarified its ruling on payment in cases of acute emotional disorders complicating maternity care.

During the antepartum period, Medicare says in-hospital care for eligible dependents may be authorized for limited periods if the emotional upsets "constitute an actual complication jeopardizing pregnancy."

To come under the Medicare program for in-hospital treatment of postpartum psychosis, admission must have occurred during the authorized 6-week postpartum period. The maximum government liability will be limited to the management of the acute phase.

Requests for payment of both hospitalization and doctors must include clinically detailed certificates signed by the attending physician or the physician providing psychiatric treatment. The certificates must also indicate that the patient's illness was in an acute phase from the time of admission through the period covered by the claim.

No payment is authorized for pseudocycsis or its management, or for outpatient care for acute emotional disorders.

Local contractors may pay claims when the hospitalization does not exceed 21 days. When management of the acute phase is expected to exceed this limit, prior approval of payment for any additional care must be obtained from the contracting officer, Office for Dependents' Medical Care, Office of the Surgeon General, U. S. Army, Washington 25, D. C.

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In cooperation with the American Psychiatric Association, the National Association for Mental Health is co-sponsoring a 2-year study of insurance coverage for psychiatric illness, a project of Group Health Insurance, Inc. The investigation is being financed with a \$300,000 grant from the National Institute of Mental Health and with \$150,000 in Group Health Insurance funds.

The total amount is expected to pay for

psychiatric services to 1,500 patients in the New York City area and to cover the cost of organizing the study and evaluating the findings.

The new services will be available at no extra cost to about 77,000 individuals—30,000 GHI subscribers and their dependents—divided about as follows: 50% unskilled or semi-skilled, 25% clerical, 17% skilled, 4% executive and 4% professional. All were enrolled before there was any announcement of the psychiatric project.

Under the plan, those needing psychiatric service may receive:

- Up to 15 sessions of individual psychotherapy in a doctor's office, with GHI paying \$15 per session and the patient paying \$5.
- Group psychotherapy up to a maximum, in combination with individual therapy, of \$225. GHI will pay \$3 per group session and the patient will be expected to pay \$1.
- Anesthesia at \$10 per treatment, if a specialist other than a psychiatrist gives electroshock therapy.
- Psychological tests to a maximum of \$45 if prescribed by a psychiatrist and given by a licensed psychologist.

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A new departure in psychiatric treatment has been undertaken by the Veterans Administration.

The agency's first mental hygiene day center for the treatment of veterans with service-connected mental illness was established recently at the VA outpatient clinic in Brooklyn, N. Y. The VA expects that more of its mental hygiene clinics will establish similar centers within the next few years.

The day center program is designed primarily to provide more and better outpatient treatment for the increasing num-

ber of veterans being released from VA hospitals after treatment for service-connected schizophrenia. Many of these veterans recovering from schizophrenia need a great deal of help through the VA outpatient treatment program if they are to adjust to community living and avoid re-hospitalization.

The Brooklyn clinic director, Dr. Philip R. Casesa, said some 75 patients will spend the major part of their time at the new day center in a therapy and planned living program under supervision of psychiatrists, psychologists and social workers.

In addition to individual and group psychotherapy and educational and occupational therapy, this program will include social and recreational activities carried out with the assistance of volunteers from the community.

In contrast, the regular VA outpatient mental treatment program provides for about two hours of psychotherapy per patient at a VA clinic weekly.

New tranquilizing drug therapies and improved treatment programs are increasing the number of patients being released from VA mental hospitals, especially the number of those being released after hospitalization for schizophrenia.

The day center is part of VA's continuing efforts to explore new methods of psychiatric rehabilitation. Other programs include:

1. Return of selected patients to communities through foster-home care.

2. Return of patients to the community at night after daytime treatment, or to daytime jobs in the community with treatment at night.

3. Selection of long-term mental patients for salaried employment at VA hospitals, to condition them for normal work and social life.

These programs are designed to help

the patient make a smooth transition from hospital to home environment. Emphasis is placed on group therapy, resocialization techniques and other rehabilitation methods.

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A 20% increase in the number of veterans with severe mental illness recovering and leaving Veterans Administration hospitals on trial visits to their home communities was reported by the agency in April.

The VA said its hospitals placed 8,076 mental patients on trial visits during the first six months of fiscal 1959. This is a 20% increase over the 6,736 patients placed on trial visits from VA hospitals during the first six months of fiscal 1958.

The 13,332 placed on trial visits during fiscal 1958 is only a slight increase over the 13,200 in fiscal 1957 but is an 8% increase over the 12,351 in fiscal 1956, a 34% increase over the 9,985 in fiscal 1955, and a 75% increase over the 7,617 in fiscal 1953.

Most of the patients leaving the hospitals on trial visits have been treated for severe mental conditions, the VA said.

The average daily patient load of mentally ill veterans in VA hospitals has remained at around the same number since the beginning of fiscal 1956, following an increase between 1953 and 1956. Currently, the figure is 57,103, which includes 51,871 veterans with severe mental illness and 5,232 with less severe psychiatric disorders.

The VA said the increase in patients on trial visit can be attributed to changes in therapies (including use of tranquilizing drugs and more emphasis on individual and group psychotherapy), to an increase in open wards, and to reawakened interest in development of new habits of resocialization to prepare patients for return to community living.



## TRAINING

The 100th mental health in-service training grant has been awarded by the Southern Regional Education Board, according to Dr. Paul W. Penningroth, SREB assistant director for mental health and director of the grant program.

The grants have been awarded since June 1958 to enable employees of mental hospitals and training schools in the South to study care and treatment in institutions anywhere in the country. Awards up to \$500 are made to cover transportation, room and board for four weeks or less.

"These visits are made possible so that anyone working in a mental institution can observe first-hand a new or better way of doing his job," Dr. Penningroth said.

An average of \$245 has been awarded to mental health personnel in 11 southern states. Physicians, nurses, social workers, therapists and educators have received most of the grants, but a wide variety of other specialties are represented including hospital chaplains, librarians, food service managers, ward attendants and volunteer coordinators, among others.

Grantees have gone to many different institutions in 22 states and Canada. More than half of the visits were made to New York, Kansas, Connecticut, the District of Columbia and Pennsylvania.

Funds for the 2-year grant program were provided to the SREB by the National Institute of Mental Health. Applications for grants are being accepted continuously until June 1960. Inquiries should be addressed to Dr. Penningroth at the Southern Regional Education Board, 130 6th St., N.W., Atlanta 13.

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The University of Cincinnati College of Nursing and Health offers programs pre-

paring clinical specialists in both adult and child psychiatric nursing which lead to the degree of Master of Science in Nursing.

The program for clinical specialists in child psychiatric nursing prepares psychiatric nurses to work with individuals and small groups of emotionally disturbed children in psychiatric inpatient residential treatment centers. The 3-semester program includes intensive study of child growth and development and of dynamic psychiatry, along with guided field work in a residential child treatment home, state hospital children's inpatient service and other community agencies.

The program for clinical specialists in adult psychiatric nursing is focused on developing an expert practitioner to work effectively with patients individually and in groups. Opportunities are available for the study of the psychodynamic aspects of the patient's illness for interdisciplinary participation in the treatment of patients and for the investigation of clinical problems in psychiatric nursing.

Further information is available from the director of the university's programs for graduate nurses, 426 College of Pharmacy Building, Cincinnati 21, Ohio.

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A teaching film, "Psychiatric Nursing: The Nurse-Patient Relationship," is available from Smith Kline & French Laboratories, Philadelphia. Designed as a service to the nursing profession, it was sponsored by the mental health education unit of SKF and produced cooperatively by the SKF medical film center and the American Nurses' Association and National League for Nursing.

## PUBLIC INFORMATION

The intensive public education campaign waged by the National Association for Mental Health and its affiliates in the last

few years is beginning to pay off, according to Harry Milt, public relations director.

Dramatic testimony to the campaign's effectiveness is provided in the results of a recent Elmo Roper poll. It showed that next to education, the American people are most willing to be taxed to pay for the care and treatment of the mentally ill.

To a nation-wide sample of the adult population Roper interviewers put this question: "Here is a list of things that are paid for by tax money. Would you be willing to see taxes raised so that more money could be spent on any of the things on this list? Which things?"

Those polled answered: "Public schools 36%, mental institutions 32%, social security benefits 24%, unemployment compensation 17%, police and law enforcement 14%, streets and highways 13%, prisons and reformatories 9%, public sanitation and garbage disposal 7%, parks and recreation facilities 6% and postal service 3%."

Commenting on these percentages, the Roper Associates said: "That public schools come out first on the list of items the public wants to see more money spent on is perhaps not surprising. The number two item is more surprising.

"The frequent mention of mental institutions is dramatic testimony to the effectiveness of recent public education campaigns on the need for adequate care and treatment of the mentally ill."

The poll was taken last October and the results published in December.

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A psychiatry class for lawyers, believed to be the first of its kind in the U.S., has been set up by the Mental Health Association of San Mateo, Calif. More than 30 practicing attorneys enrolled for the 8-week course, co-sponsored by the College of San Mateo and the Bar Association.

The Dallas Association for Mental Health and Junior Bar Association are also sponsoring a program designed to give attorneys a better understanding of the various types of mental illness and their manifestations.

## AWARDS

Dr. Donald Ewen Cameron of McGill University, Montreal, president of the Canadian Psychiatric Association and past president of the American Psychiatric Association, is the 1959 recipient of the \$2,500 Samuel Rubin award for outstanding achievements in mental health. The award was presented April 17 in New York City.

Dr. Cameron was selected for the award by a professional committee under the chairmanship of Dr. Lewis R. Wolberg, medical director and dean of the Postgraduate Center for Psychotherapy in New York City, a non-profit organization which provides therapy for persons of low income and conducts advanced training and research programs in psychotherapy.

Dr. Paul R. Hoch, New York State mental hygiene commissioner and first recipient of the award in 1957, made the presentation for the Samuel Rubin Foundation.

\* \* \*

Irving L. Janis, Ph.D., associate professor of psychology at Yale University, is winner of the American Psychiatric Association's \$1,500 Hofheimer prize for research for 1959, it was announced in May at the APA's annual meeting in Philadelphia.

Dr. Janis was selected by a board of six APA fellows for research described in his book *Psychological Stress: Psychoanalytic and Behavioral Studies of Surgical Patients*. On the basis of his studies he hypothesized that "in adult life, exposure to any signs of potential mutilation or annihilation will tend to reactivate the seemingly outgrown

patterns of emotional response which had originally been elicited and reinforced during the stress episodes of early childhood." In extensive preoperative and postoperative interviews with surgical patients Dr. Janis elicited much data of potential usefulness in preparing patients psychologically for surgical stress.

A native of Buffalo, the 41-year-old researcher received his B.S. degree from the University of Chicago in 1939 and his Ph.D. from Columbia in 1949. He has held numerous fellowships and research awards from the Social Science Research Council, New York Psychoanalytic Institute and Ford Foundation, and a Fulbright research award. He has made many contributions to psychiatric and psychological literature since 1943. He was a joint author with Samuel A. Stouffer of the classic study entitled *The American Soldier* published in 1949.

The Hofheimer prize was established in 1947 in honor of Lt. Lester N. Hofheimer of New York City, who lost his life in action in the Mediterranean in World War II. The recipient must be under 40 at the time the research is submitted for publication.

\* \* \*

Dr. Maxwell Jones, eminent British psychiatrist, is the eighth winner of the American Psychiatric Association's \$1,000 Isaac Ray award, given annually to a psychiatrist or member of the bar for furthering understanding between the two professions.

As recipient, Dr. Jones will deliver a series of lectures on psychiatry and the law at George Washington University in Washington, D. C., in the next academic year under the joint auspices of the university's law and medical schools.

Dr. Jones is especially noted for his success in treating and rehabilitating adults with personality disorders of the anti-social

type at Belmont Hospital in Sutton, Surrey, England, where he directs the social rehabilitation unit. He has been a foremost leader in developing the concept of the mental hospital as a "therapeutic community." The concept emphasizes the functioning of the hospital as a social system. The typical therapeutic community stresses open doors, patient government, democratic group participation and related practices as part of the total treatment program. It operates on the premise that where good and reasonable behavior is expected, patients will respond to the expectation.

Since 1949 Dr. Jones has been on the council of the Institute of Human Relations at Tavistock Clinic in London. His major work, *The Therapeutic Community* was published by Basic Books in 1953. He is a corresponding fellow of the American Psychiatric Association.

The award commemorates Dr. Isaac Ray, a founder of APA, whose remarkable *Treatise on the Medical Jurisprudence of Insanity*, published in 1838, was for many years the standard work on the subject.

\* \* \*

The *Pharos-Tribune* of Logansport, Ind., has been adjudged the winner of the 1959 National Mental Health Bell Award in recognition of its consistent editorial support in the fight against mental illness. The award was presented at special ceremonies of the Indiana Association for Mental Health.

A special citation of merit to the Albany, N. Y., *Knickerbocker News* also was awarded by the Mental Health Bell Award committee for that paper's sustained and successful editorial efforts in bringing about the establishment of the Albany County Mental Health Board. The citation was presented May 17 in Albany at a dinner meeting during the 4th annual conference



of the New York State Association of Community Mental Health Boards. Robert Barrie, executive director of the New York State Society for Mental Health, made the presentation on behalf of the National Association for Mental Health, the Albany County association and the New York state society.

Selection of the *Pharos-Tribune* was based on its year-round coverage of developments in the field of mental illness, advocacy of improvements in the treatment and prevention of mental illness, and editorial support of the program and activities of the mental health associations.

The Mental Health Bell Award is presented each year to an American daily newspaper which during the preceding year made an outstanding contribution to the fight against mental illness. The bronze plaque is a replica of the historic 300-pound Mental Health Bell cast in 1953 from chains and handcuffs formerly used to restrain mental patients.

Other American newspapers which have won the award are the *Columbus, Ga., Enquirer*, 1958; *Arizona Republic*, 1957; *Austin, Texas, American-Statesman*, 1956; *Indianapolis Times*, 1955; *Hartford Courant*, 1954; and *Baltimore Sunpapers*, 1953.

\* \* \*

"Bitter Welcome," a new film about the problems of the returning mental patient, was awarded a blue ribbon as the best mental health film of the year at the Educational Film Library Association's film festival.

## APPOINTMENTS

Dr. Warren T. Vaughan, director of the children's unit, at Metropolitan State Hospital in Massachusetts, has been appointed director of the mental health program of

the Western Interstate Commission for Higher Education. His office will be located at the WICHE headquarters on the University of Colorado campus in Boulder.

The commission is a regional public agency set up by 12 western states to promote regional cooperation in higher education. The WICHE mental health program is concerned with training and research and is financed through a grant from the National Institute of Mental Health.

As the head of this project, Dr. Vaughan will direct his efforts toward the development of programs to increase the West's supply of mental health personnel and to promote research in mental health.

According to Dr. Harold Enarson, executive director, "Dr. Vaughan's training and background make him eminently qualified to direct this mental health work in the West. As a psychiatrist who has been concerned with community mental health services for many years, he will bring to his work an ideal combination of experience in administration, teaching, psychiatric practice and research."

From 1953 to 1957 Dr. Vaughan served as director of the division of mental hygiene in the Massachusetts Department of Mental Health. In this capacity he developed a state-wide program of community mental health services that received national recognition. Since 1953 he has been on the faculty of the Harvard School of Public Health. He has served for 10 years as a consulting psychiatrist for several school systems in Massachusetts. Last year he completed an assignment as associate director of a task force of the Joint Commission on Mental Illness and Health.

In the field of research Dr. Vaughan has directed a state survey of community mental health resources in Massachusetts and a study of psychiatric services in Con-

necticut general hospitals. He has written widely in the fields of community and school mental health. He is currently engaged in an analysis of day hospitals for children.

During World War II Dr. Vaughan served as a captain in the Medical Corps immediately following his graduation from Harvard Medical School.

Dr. Vaughan succeeds Dr. Daniel Blain, former medical director of the American Psychiatric Association, who recently resigned to become director of the California Department of Mental Hygiene.

\* \* \*

Sidney Spector of Chicago, director of the Interstate Clearing House on Mental Health, has been appointed staff director of the Senate subcommittee on problems of the aged and aging. He has filled many important posts for the Council of State Governments and the Governors' Conference and has written a number of significant reports on mental health conditions in the U.S.

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Dr. Roger W. Howell of Detroit has been appointed associate professor of public health administration at the University of Michigan. He joins the School of Public Health in July as its first full-time psychiatrist.

Since 1956, Dr. Howell has been director of preventive psychiatry at the Lafayette Clinic in Detroit and associate professor of psychiatry at Wayne State University.

## MEETINGS

Dr. Jack R. Ewalt, director of the Joint Commission on Mental Illness and Health, will give the keynote speech at the opening general session of the 9th annual meeting of the National Association for Mental

Health, set for November 19 in Philadelphia.

The meeting will mark the 50th anniversary of the formation of a national citizens' mental health organization.

Dr. Ewalt will touch on four general topics: better care and treatment for hospitalized mental patients, rehabilitation services, services for emotionally-disturbed children, and research in mental illness. Each will be discussed in detail in subsequent half-day workshops or general sessions.

Also on the schedule are regional dinners focusing on the need for more funds for services to the mentally ill; curbstone conferences on fund-raising, field service, public relations, education, volunteer services and mental health education; breakfast-time film showings; and four business sessions, two for the NAMH board and two for the membership.

The annual banquet, set for November 20, will take as its theme "Fifty Years of Progress in the Fight against Mental Illness."

A summing-up and a look to the future will be provided by a speaker of eminence at a final luncheon November 21.

Preceding the annual assembly will be a national institute sponsored by NAMH for executive directors and other staff members of state and local mental health associations. It is scheduled for November 16-18, also in Philadelphia.

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"New Horizons in Psychiatry" will be the theme of a divisional meeting of the American Psychiatric Association October 29-31 in Detroit.

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The annual meeting of the National Council on Family Relations will be held

August 19-21 at Iowa State College, Ames. The theme will be "Growing Individual Values within the Family."

In addition to general sessions with outstanding speakers, there will be sessions on cooperative nursery schools, research, parent education, religion, counseling, and family life education in the community, schools and colleges, according to Dr. Aaron Rutledge, president-elect and program chairman.

Attendance is open to all. Further details are available from the council, 1219 University Ave., S.E., Minneapolis 14.

\* \* \*

The 17th annual meeting of the American Psychosomatic Society will be held March 26-27, 1960 in Montreal.

Taking office at the last annual meeting, held May 2-3 in Atlantic City, were Dr. Eric D. Wittkower, president; Dr. Morton F. Reiser, president-elect, and Dr. Eugene Meyer, secretary-treasurer. Elected to the council were Drs. George L. Engel, David A. Hamburg and David R. Hawkins.

\* \* \*

Dr. Robert H. Felix, director of the National Institute of Mental Health, has been named president-elect of the American Psychiatric Association. He will take office next May.

At the recent APA meeting in Philadelphia, Dr. William Malamud, research director for the National Association for Mental Health, assumed the presidency, to which he was elected last year.

Other APA officers include Dr. Franklin G. Ebaugh of the University of Colorado School of Medicine and Dr. Spafford Ackery of the University of Louisville School of Medicine, vice-presidents; Dr. C. H. Hardin Branch, University of Utah School of Medicine, re-elected secretary; Dr. Addison M. Duval of the Missouri Depart-

ment of Public Health and Welfare, treasurer; Dr. Paul H. Hoch, New York's mental hygiene commissioner, Dr. A. B. Stokes of the University of Toronto School of Medicine and Dr. Calvin S. Drayer of the Institute of the Pennsylvania Hospital, councillors.

\* \* \*

Dr. Edward L. Bortz, formerly president of the American Medical Association, leader in geriatrics, and now chief of medical service at Lankenau Hospital in Philadelphia, has been named chairman of the 1960 National Health Forum.

The forum, an annual national conference, is sponsored by the National Health Council on behalf of its more than 60 member agencies. The 1960 forum will be held in Miami Beach the week of March 13. Discussions will center on the health of old people.

"The annual National Health Forums enable leaders in health and other organizations to consider together an important national problem which requires public and professional attention and action by many groups," Miss Ruth Freeman, council president, said. "The health problems of the aging need to be analyzed and call for individual and community action. They involve social as well as economic and psychological considerations. Solutions depend upon mutual study and action by many groups in addition to the medical and related health professions."

## PUBLICATIONS

The contributions—past, present and potential—of volunteers in advancing the treatment and care of mental patients are comprehensively set forth in a new book called *The Volunteer and the Psychiatric Patient*.



It is based on a conference held last June in Chicago under the auspices of the National Association for Mental Health, American Psychiatric Association, National Institute of Mental Health, American Hospital Association, Veterans Administration and American Red Cross.

The book tells what volunteers do and where they do it; how they are recruited, screened, trained and supervised; how volunteer programs are administered; and what potential exists for expanding the use of volunteers outside hospitals.

A feature of the book is a bill of rights for mental patients. It was drafted by Dr. John J. Blasko and endorsed by the conference as useful in calling attention to specific needs and rights of the mentally ill. The book also contains helpful statistics, lists of agencies which supply volunteers, sample job descriptions, reading lists and so on. It is available for \$2.50 a copy from the APA, 1700 18th St., N.W., Washington 6, D. C.

\* \* \*

Tax and fiscal problems underlying state mental health and hospital programs are analyzed in a new monograph published by the American Psychiatric Association. It was written by Sidney Spector, known to mental health associations throughout the country as director of the Interstate Clearing House on Mental Health.

Copies of *Tax and Fiscal Policy and State Mental Health Programs* are available free from the APA, 1700 18th St., N.W., Washington 6, D. C.

\* \* \*

The April 1959 issue of the *American Sociological Review* was devoted almost entirely to articles on deviant behavior. Among the titles and authors were "Deviant Behavior and Social Structure: Con-

tinuities in Social Theory" by Robert Dubin, "Illegitimate Means, Anomie and Deviant Behavior" by Richard A. Cloward, "Social Conformity, Deviation and Opportunity Structures: A Comment on the Contributions of Dubin and Cloward" by Robert K. Merton, and "Antisocial Sentiment and Criminality" by Gwynn Nettler.

Copies are available for \$2 each from the American Sociological Society, New York University, Washington Square, New York 3.

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*Growing Up in a Changing World* is a compilation of papers presented at the 10th annual meeting of the World Federation for Mental Health, held in Copenhagen in 1957. The volume is available from WFMH, 162 E. 78th St., New York 21, for \$2.50.

\* \* \*

A new consultation service for the planning, designing and equipping of psychiatric facilities has been instituted by the American Psychiatric Association. It is available to architectural and engineering firms, heating and lighting experts, equipment and furniture manufacturers, community organizations, government agencies, hospital planning commissions and other interested groups.

The architectural service staff will make available a considerable collection of information and material on the construction of public and private psychiatric hospitals, psychiatric units in general hospitals, mental health clinics, day and night hospitals, half-way houses, sheltered workshops, residential units for children and special facilities for the aging.

One of the service's first contributions is the publication of *Psychiatric Architecture*, a 156-page review of contempo-

rary developments in the field. In addition to 45 color pictures of mental hospitals abroad, the book contains extensive glossaries, a check list for planning construction, and contributions by 24 psychiatrists and architects. It is available for \$10 a copy from the APA, 1700 18th St., N.W., Washington 9, D.C.

## MENTAL RETARDATION

In the judgment of the Council of State Governments, one of the urgent problems facing every state today is that of formulating and carrying out a coordinated, comprehensive program of services for the mentally retarded.

Two years ago the council formed a committee on mental retardation, composed of some of the nation's leading students and practitioners in the field. This committee has given special attention to developing guides for the states in organizing effectively to meet the problems of the mentally retarded.

To assist in its deliberations, the committee called a conference on mental retardation November 20-21, 1958 in New York City, with representatives from many fields and from all sections of the country. After two days of intensive discussion and after further critical review by the committee, a series of recommendations were adopted on state organization, modernizing commitment legislation and financing programs for the mentally retarded.

The report and recommendations of that conference follow:

### Statement of Purpose

On November 20-21, 1958, the committee on mental retardation of the Council of State Governments called a special conference of outstanding leaders in the field

of mental retardation, to develop a comprehensive program for guidance to the states.

In few areas of state government has there been such intense pressure in recent years for the enactment of an effective program to meet the needs of the mentally retarded—young and old. State institutions at present are heavily overcrowded with more than 140,000 residents of all ages and of varying degrees of retardation and mental defect. Buildings are obsolete, archaic and unsuited for a modern treatment program in many instances. Waiting lists for entry into institutions have reached heart-breaking—in fact, politically sensitive—proportions. Thousands of educable and trainable retarded people are receiving no education and no training, and little care. Diagnostic facilities are scarce, and personnel trained and qualified to work in the field is even rarer.

And yet, one of the nation's top research scientists in the field of mental retardation stated that if we did everything we could possibly do today, based on the knowledge that we have today, we probably would prevent *at least* one-half of the cases of mental defect and mental retardation that we know will occur.

As a result, parent groups, relatives of families with retarded children, people with interest and concern for a handicapped group as well as taxpayers visualizing large and costly building programs have focused national attention on this problem to the highest degree that we have known.

Governors and legislators and other state officials as never before are attempting to meet the needs of the mentally retarded and are seeking advice and guidance on how best to organize effective, comprehensive state programs to prevent mental retardation, where possible, to deal with it early, when needed, and to provide voca-

tional and educational facilities in order to keep as many in the community as possible.

It was to assist in responding to this overriding question that the Council of State Governments called this 2-day conference of experts from the fields of education, welfare, health, mental health and employment, and from state government, the federal government and the universities. Included also was a substantial number of legislators from as far west as Oregon and California to as far east as Connecticut, New Hampshire and New York. All of them knew well the problems of the mentally retarded, following long, serious study and reports as members of legislative committees.

Out of these two full days of lectures and intensive discussion, the conference developed a set of recommendations designed to assist the states in dealing with the following three major questions:

1. What kind of administrative organization is required by the states to carry out a comprehensive program in the field of mental retardation?

2. What kind of legislation should our states pass to modernize their commitment and discharge procedures?

3. What financial arrangements are necessary to execute a comprehensive program?

#### State Administrative Organization

The problems of the mentally retarded are not and cannot be the sole responsibility of any one department of state government. They are important concerns of several departments and require a multiple but coordinated attack.

1. The conference therefore recommended that each state establish an interdepartmental agency, such as an interdepartmental committee, council or board, for the joint

planning and coordination of state services for the mentally retarded. This interdepartmental agency may be established by the Governor or the legislature, depending upon conditions prevailing in the state.

2. Such departments as education, mental health, health, welfare, labor, corrections and institutions of higher education offer programs and services for the mentally retarded. Within a given state there may be other departments concerned with the mentally retarded. Within each of these departments there should be a division or bureau for services to the mentally retarded or a special consultant with specific responsibility for the development and administration of these services.

3. In order to implement these recommendations, the conference recommended that:

Each department head or his deputy should report to the interdepartmental agency on the responsibility of his department for services to the mentally retarded and on the extent to which these services are provided.

The interdepartmental agency should submit reports periodically, with recommendations for legislative and administrative action to improve services for the mentally retarded.

4. A comprehensive program for the mentally retarded should include intensive efforts to prevent mental retardation in the first place. This means: services to prevent birth defects, prenatal care, pediatric care, child health supervision and safety provisions. The state program should also include diagnostic services for development evaluation, an extensive research effort, provisions for the training of professional personnel, and intensive programs for the care, training and welfare of the mentally retarded.

5. To increase the efficient use of per-



sonnel and facilities in research, training and treatment, the states should explore the potential of pooling resources within regions for cooperative interstate efforts.

6. Wherever possible, services for the mentally retarded should be provided at the community level, with state assistance where needed. State provision should complement services provided at the community level.

7. Any program providing a comprehensive approach to the problems of the mentally retarded must include provision for joint planning between state agencies and local government agencies.

8. Particular attention should be given to the problem of providing appropriate services to the mentally retarded in the rural areas of the states.

9. An effective program for the mentally retarded will give emphasis to services for very young children.

10. Lay groups concerned with the problems of mental retardation should participate in an advisory capacity to those agencies established by the state to deal with the problem.

### Modernizing Commitment and Discharge Legislation

The conference adopted the view that major emphasis should be placed on voluntary admissions to institutions for the mentally retarded, rather than judicial proceedings.

The conference recognized that judicial commitments will still be required for a small group of mentally retarded individuals who also are afflicted with severe behavior disorders.

These instances, however, will be relatively few, and the whole trend, the conference agreed, is in the direction of early

voluntary admissions and intensive treatment.

1. Judicial Commitment. When judicial commitment is applied for, provision should be made for referring the case to appropriate community resources for diagnostic evaluation. These community resources should consist of persons competent to make medical, psychological and social evaluations.

The total evaluation should consist of the determination as to whether or not the person is mentally retarded and is suitable for and in need of institutional care.

Upon receipt of the report of evaluation, the court should be required to reject the petition if the evaluation is negative. The court, however, should have jurisdiction to commit or not commit in the event that the evaluation is affirmative.

If the court determines that commitment should be made, it must communicate with the authorities of the proper agency to which it proposes to commit with respect to the availability of space and facilities for the person; if the report from the agency is in the negative, the court must withhold commitment until advised by such authorities that space and facilities are available.

The authorities of an institution should be authorized to take such action with reference to release, parole or other action with regard to a committed behavior problem child which they deem appropriate as in the case of any other committed patient; but in the event such authorities are of the opinion that the child properly belongs in another type of institution they shall be permitted to apply to the committing court for revocation of such commitment and for commitment to another institution.

The commitment should not constitute an adjudication of incompetency for any purpose other than institutionalization.

2. **Voluntary Admission.** The same process of evaluation in a community diagnostic facility competent to make medical, psychological and social evaluation should be a prerequisite to voluntary admission as is provided for under judicial commitment.

Upon application of the parent or guardian and after evaluation which determines that the child should be admitted, a certificate of admission should be executed by the evaluating resource, which would confer jurisdiction on the authorities of the institution or hospital to hold for care and treatment and to return from unauthorized leave any person granted admission, provided that such person shall not be retained for more than 30 days after the receipt of a request from the parent or guardian of a person under maturity age, or the person himself after reaching maturity age or any relative or friend on his behalf, for release of such person. Within such 30 days, the authorities of the institution or hospital may petition for judicial commitment, and such release shall be withheld pending the decision of the court.

#### Financing an Effective Program

1. **Research.** The conference adopted the principle that research in the field of mental retardation is essential, and no state program can be effective without devoting state funds for this purpose. In order to establish a productive research effort, including research in prevention, state funds are required to provide a core staff of investigators who can look forward to long-term research activity. Furthermore, mental retardation is uniquely a problem for state governments, and research is essential to evaluate how well the states are carrying on their own programs.

The conference therefore recommended that every state appropriate funds for research in the field of mental retardation and that these funds should be made available on a continuing basis for use in a flexible manner. Funds for research can be provided through investing a portion of the fees paid by financial responsible relatives into a research fund dedicated for this purpose.

2. **Relative Responsibility.** The committee recommended that the states should adopt the principle that parents or responsible relatives financially equipped to pay for the care of their mentally retarded should do so. However, safeguards should be written into the law to ensure that in no instance will such payment cause financial hardship to the family.

It also was recommended that the states should review their payment legislation and consider the possibility of setting some maximum related to the cost of care as the basis for payment.

3. **State-Local Sharing in Cost of Education.** The conference felt that communities should provide suitable education and training for every child and that incentive programs are needed, financed in part by the state, to ensure the education and training of the special categories which require heavier financial investment.

The conference therefore recommended that every state adopt mandatory legislation for the education of the educable mentally retarded and at least permissive legislation for the trainable mentally retarded and that the state assume the obligation of paying the local school district or community for the additional cost involved in the provision of these educational programs.

4. **Departmental Services.** The conference felt that state health, employment, corrections and welfare agencies providing

various services for children and adults should include the mentally retarded in the services that they provide, in order to achieve the most efficient use of existing resources.

The conference therefore recommended that these agencies, whether community or institutional, include the mentally retarded in the services provided by them. It further recommended that increased appropriations should be made available to these employment, health, corrections and welfare agencies and that the funds should be budgeted for the purpose of services to the retarded, at least initially.

5. Personnel. The conference agreed that personnel employed in state institutions for the mentally retarded, although devoted to their work and highly trained in many instances, generally have a lower level of employment prestige and that special financial inducements are required to raise the prestige of employment in the institutional system.

The conference therefore recommended that competitive salaries be provided for personnel trained in the field of mental retardation and that special inducements should be offered in order to attract and retain the best qualified personnel. In the long run, the conference felt, this step would be most efficient and economical.

The conference further recommended that state and federal funds be provided to training centers for academic training, at advanced levels, of personnel in the field of mental retardation. A great need, the conference felt, was the training of teachers and others who in turn could train other personnel.

The conference further recommended that state agencies concerned with mental retardation develop and carry out programs of in-service training for non-professional personnel and that funds be made available for this purpose.

6. Hill-Burton Funds. The conference recommended that Hill-Burton funds be increased generally and be made available for the construction of institutions for the mentally retarded.

7. State-Local Finances. The conference agreed that to every extent possible services for the mentally retarded be community-based. In many instances this will mean financial assistance by the state for such community facilities as day care centers, recreation activities, sheltered workshops, educational facilities, etc.

The conference therefore recommended that provision be made for states and communities to share in the cost of providing community facilities for the retarded, both for non-profit and public agencies but under full and ample supervision by the state.

8. Maternal and Child Health Grants. The conference recommended that federal maternal and child health grants should not be limited to public health departments but should be made available more flexibly to the agencies designated by the state.

9. Cost Projections. The conference recommended that the states develop plans and project their costs for the next ten years with respect to their building programs and operations on the basis of the best current thought in the field. This would require careful consultation with leading experts as to the best knowledge available today and the cost involved in putting this knowledge into effect.



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## *Notes and Comments*

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SIDNEY M. JOURARD, PH.D.

# Healthy personality and self-disclosure

For a long time, health and well-being have been taken for granted as "givens," and disease has been viewed as the problem for man to solve. Today, however, increasing numbers of scientists have begun to adopt a reverse point of view, regarding disease and trouble as the givens, with specification of positive health and its conditions as the problem to solve. Physical, mental and social health are values representing restrictions on the total variance of being. The scientific problem here consists in arriving at a definition of health, determining its relevant dimensions and then identifying the independent variables of which these are a function.

Scientists, however, are supposed to be hard-boiled, and they insist that phenomena, to be counted "real," must be public. Hence, many behavioral scientists ignore man's self, or soul, since it is essentially a

private phenomenon. Others, however, are not so quick to allocate man's self to the limbo of the unimportant, and they insist that we cannot understand man and his lot until we take his self into account.

I probably fall into the camp of those investigators who want to explore health as a positive problem in its own right, and who, further, take man's self seriously—as a reality to be explained and as a variable which produces consequences for weal or woe. This paper gives me an opportunity to explore the connection between positive health and the disclosure of self. Let me commence with some sociological truisms.

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Dr. Jourard, an associate research professor in psychology and nursing at the University of Florida College of Nursing, presented this paper November 20, 1958 at a meeting of the North Florida section of the American Personnel and Guidance Association.



Social systems require their members to play certain roles. Unless the roles are adequately played, the social systems will not produce the results for which they have been organized. This flat statement applies to social systems as simple as that provided by an engaged couple and to those as complex as a total nation among nations. Societies have socialization "factories" and "mills"—families and schools—which serve the function of training people to play the age, sex and occupational roles which they shall be obliged to play throughout their life in the social system. Broadly speaking, if a person plays his roles suitably, he can be regarded as a more or less normal personality. Normal personalities, however, are not healthy personalities (Jourard 1958, 16-18).

Healthy personalities are people who play their roles satisfactorily, and at the same time derive personal satisfaction from role enactment; more, they keep growing and they maintain high-level physical wellness (Dunn 1958). It is probably enough, speaking from the standpoint of a stable social system, for people to be normal personalities. But it is possible to be a normal personality and be absolutely miserable. We would count such a normal personality unhealthy. In fact, normality in some social systems—successful acculturation to them—reliably produces ulcers, paranoia, piles or compulsiveness. We also have to regard as unhealthy personalities those people who have never been able to enact the roles that legitimately can be expected from them.

Counselors, guidance workers and psychotherapists are obliged to treat with both patterns of unhealthy personality—those people who have been unable to learn their roles and those who play their roles quite well but suffer the agonies of boredom, frustration, anxiety or stultification. If our clients are to be helped they must change,

and change in valued directions. A change in a valued direction may arbitrarily be called growth. We have yet to give explicit statement to these valued directions for growth, though a beginning has been made (Fromm 1947, Jahoda 1958, Jourard 1958, Maslow 1954, Rogers 1954). We who are professionally concerned with the happiness, growth and well-being of our clients may be regarded as professional lovers, not unlike the Cyprian sisterhood. It would be fascinating to pursue this parallel further, but let it suffice for us to be reminded that we do in fact share membership in the oldest profession in the world. Our branches of this oldest profession probably began at the same time that our sisters' branch began, and all branches will continue to flourish so long as they meet the needs of society. We are all concerned with promoting personality health in the people who consult with us.

Now what has all this to do with self-disclosure?

To answer this question, let's tune in on an imaginary interview between a client and his counselor. The client says, "I have never told this to a soul, doctor, but I can't stand my wife, my mother is a nag, my father is a bore, and my boss is an absolutely hateful and despicable tyrant. I have been carrying on an affair for the last ten years with the lady next door and at the same time I am a deacon in the church." The counselor says, showing great understanding and empathy, "Mm-humm!"

If we listened for a long enough period of time we would find that the client talks and talks about himself to this highly sympathetic and empathic listener. At some later time the client may eventually say, "Gosh, you have helped me a lot. I see what I must do and I will go ahead and do it."

Now this talking about oneself to another

person is what I call self-disclosure. It would appear, without assuming anything, that self-disclosure is a factor in the process of effective counseling or psychotherapy. Would it be too arbitrary an assumption to propose that people become clients because they have not disclosed themselves in some optimum degree to the people in their life?

An historical digression: Toward the end of the 19th century Joseph Breuer, a Viennese physician, discovered (probably accidentally) that when his hysterical patients talked about themselves, disclosing not only the verbal content of their memories but also the feelings that they had suppressed at the time of assorted "traumatic" experiences, their hysterical symptoms disappeared. Somewhere along the line Breuer withdrew from a situation which would have made his name identical with that of Freud in history's hall of fame. When Breuer permitted his patients "to be," it scared him, one gathers, because some of his female patients disclosed themselves to be quite sexy, and what was probably worse, they felt quite sexy toward him.

Freud, however, did not flinch. He made the momentous discovery that the neurotic people of his time were struggling like mad to avoid "being," to avoid being known, and in Allport's (1955) terms, to avoid "becoming." He learned that his patients, when they were given the opportunity to "be"—which free association on a couch is nicely designed to do—they would disclose that they had all manner of horrendous thoughts and feelings which they did not even dare disclose to themselves, much less express in the presence of another person. Freud learned to permit his patients to be, through permitting them to disclose themselves utterly to another human. He evidently didn't trust anyone enough to be willing to disclose *himself vis à vis*, so he

disclosed himself to himself on paper (Freud 1955) and learned the extent to which he himself was self-alienated.

Roles for people in Victorian days were even more restrictive than they are today, and Freud discovered that when people struggled to avoid being and knowing themselves they got sick. They could only become well, and stay relatively well, when they came to know themselves through self-disclosure to another person. This makes me think of Georg Groddeck's magnificent *Book of the It (Id)* in which, in the guise of letters to a naive young woman, Groddeck shows the contrast between the public self—pretentious role-playing—and the warded off but highly dynamic *id*—which I here very loosely translate as "real self."

Let me at this point draw a distinction between role relationships and interpersonal relationships—a distinction which is often overlooked in the current spate of literature that has to do with human relations. Roles are inescapable. They must be played or else the social system will not work. A role by definition is a repertoire of behavior patterns which must be rattled off in appropriate contexts, and all behavior which is irrelevant to the role must be suppressed. But what we often forget is the fact that it is a person who is playing the role. This person has a self—or, I should say, he *is* a self. All too often the roles that a person plays do not do justice to all of his self. In fact, there may be nowhere that he may just *be* himself. Even more, the person may not *know* his self. He may, in Horney's (1950) terms, be self-alienated.

This fascinating term "self-alienation" means that an individual is estranged from his real self. His real self becomes a stranger, a feared and distrusted stranger. Estrangement—alienation from one's real self—is at the root of the "neurotic personality of our time" so eloquently de-

scribed by Horney (1936). Fromm (1957) referred to the same phenomenon as a socially patterned defect.

Self-alienation is a sickness which is so widely shared that no one recognizes it. We may take it for granted that all the clients we encounter are self-alienated to a greater or lesser extent. If you ask anyone—a client, a patient, or one of the people here—to answer the question, "Who are you?" the answer will generally be, "I am a psychologist, a guidance worker, teacher or what have you." The respondent will probably tell you the name of the role with which he feels most closely identified. As a matter of fact, the respondent spends a greater part of his life trying to discover who he is, and once he has made some such discovery, he spends the rest of his life trying to play the part. Of course, some of the roles—age, sex, family or occupational roles—may be so restrictive that they fit a person in a manner not too different from the girdle of a 200-pound lady who is struggling to look like Brigitte Bardot. There is Faustian drama all about us in this world of role-playing. Everywhere we see people who have sold their souls—their real self, if you wish—in order to be a psychologist, a guidance worker, a nurse, a physician, a this or a that.

Now I have suggested that no social system can exist unless the members play their roles and play them with precision and elegance. But here is an odd observation, and yet one which you can all corroborate just by thinking back over your own experience. It's possible to be involved in a social group, such as a family or a work setting, for years and years, playing one's roles nicely with the other members—and never getting to know the *persons* who are playing the other roles. Roles can be played personally and impersonally, as we are beginning to discover in nursing. A husband can be married to his wife for fifteen years

and never come to know her. He knows her as "the wife." This is the paradox of the "lonely crowd" (Riesman 1950). It is the loneliness which people try to counter with "togetherness." But much of today's "togetherness" is like the "parallel play" of 2-year-old children, or like the professors in Stringfellow Barr's novel (1958) who, when together socially, lecture past one another alternately and sometimes simultaneously. There is no real self-to-self or person-to-person meeting in such transactions.

Now what does it mean to know a person, or, more accurately, a person's self? I don't mean anything mysterious by "self." All I mean is the person's subjective side—what he thinks, feels, believes, wants, worries about, his past and so forth—the kind of thing one could never know unless one were told. We get to know the other person's self when he discloses it to us.

Self-disclosure, letting another person know what you think, feel or want, is the most direct means (though not the only means) by which an individual can make himself known to another person. Personality hygienists place great emphasis upon the importance for mental health of what they call "real self being," "self-realization," "discovering oneself" and so on. An operational analysis of what goes on in counseling and therapy shows that the patients and clients discover themselves through self-disclosure to the counselor. They talk, and to their shock and amazement the counselor listens.

I venture to say that there is probably no experience more horrifying and terrifying than that of self-disclosure to "significant others" whose probable reactions are assumed but not known. Hence the phenomenon of "resistance." This is what makes psychotherapy so difficult to take and so difficult to administer. If there is any skill to be learned in the art of counseling



and psychotherapy, it is the art of coping with the terrors which attend self-disclosure, and the art of decoding the language—verbal and non-verbal—in which a person speaks about his inner experience.

Now, what is the connection between self-disclosure and healthy personality? Self-disclosure, or should I say "real" self-disclosure, is both a symptom of personality health (Jourard 1958, 218–21) and at the same time a means of ultimately achieving healthy personality. The discloser of self is an animated "real self be-er." This, of course, takes courage—the "courage to be" (Tillich 1954). I have known people who would rather die than become known, and in fact some did die when it appeared that the chances were great that they would become known. When I say that self-disclosure is a symptom of personality health, what I mean really is that a person who displays many of the other characteristics that betoken healthy personality (Jourard 1958, Maslow 1954) will also display the ability to make himself fully known to at least one other significant human being. When I say that self-disclosure is a means by which one achieves personality health, I mean something like the following: It is not until I *am* my real self and I *act* my real self that my real self is in a position to grow. One's self grows from the consequence of being. People's selves stop growing when they repress them. This growth-arrest in the self is what helps to account for the surprising paradox of finding an infant inside the skin of someone who is playing the role of an adult.

In a fascinating analysis of mental distress, Jurgen Ruesch (1957) describes assorted neurotics, psychotics and psychosomatic patients as persons with selective atrophy and overspecialization in the aspects of communication. I have come to believe that it is not communication *per se* which

is fouled up in the mentally ill. Rather, it is a foul-up in the processes of knowing others and of becoming known to others. Neurotic and psychotic symptoms might be viewed as smokescreens interposed between the patient's real self and the gaze of the onlooker. We might call the symptoms devices to avoid becoming known. A new theory of schizophrenia has been proposed by an anonymous former patient (1958) who "was there" and he makes such a point.

Alienation from one's real self not only arrests one's growth as a person; it also tends to make a farce out of one's relationships with people. As the ex-patient mentioned above observed, the crucial break in schizophrenia is with sincerity, not reality (Anonymous, 1958). A self-alienated person—one who does not disclose himself truthfully and fully—can never love another person nor can he be loved by the other person. Effective loving calls for knowledge of the object (Fromm 1956, Jourard 1958). How can I love a person whom I do not know? How can the other person love me if he does not know me?

Hans Selye (1946) proposed and documented the hypothesis that illness as we know it arises in consequence of stress applied to the organism. Now I rather think that unhealthy personality has a similar root cause, and one which is related to Selye's concept of stress. It is this: Every maladjusted person is a person who has not made himself known to another human being, and in consequence does not know himself. Nor can he find himself. More than that, he struggles actively to avoid becoming known by another human being. He works at it ceaselessly, 24 hours daily, and it is work! The fact that resisting becoming known is work offers us a research opening, incidentally (DiTtes 1958, Davis and Malmo 1951). I believe that in the effort to avoid becoming known a person

provides for himself a cancerous kind of stress which is subtle and unrecognized but nonetheless effective in producing not only the assorted patterns of unhealthy personality that psychiatry talks about but also the wide array of physical ills that have come to be recognized as the stock in trade of psychosomatic medicine. Stated another way, I believe that other people come to be stressors to an individual in direct proportion to his degree of self-alienation.

If I am struggling to avoid becoming known by other persons then of course I must construct a false public self (Jourard 1958, 301-302). The greater the discrepancy between my unexpurgated real self and the version of myself that I present to others, the more dangerous will other people be for me. If becoming known by another person is a source of danger, then it follows that merely the presence of the other person can serve as a stimulus to evoke anxiety, heightened muscle tension and all the assorted visceral changes which occur when a person is under stress. A beginning already has been made in demonstrating the tension-evoking powers of the other person through the use of such instruments as are employed in the lie detector, the measurement of muscle tensions with electromyographic apparatus and so on (Davis and Malmo 1958, Dittes 1958).

Students of psychosomatic medicine have been intimating something of what I have just finished saying explicitly. They say (Alexander 1950) that ulcer patients, asthmatic patients, patients suffering from colitis, migraine and the like, are chronic repressors of certain needs and emotions, especially hostility and dependency. Now when you repress something, you are not only withholding awareness of this something from yourself; you are also withholding it from the scrutiny of the other person. In fact, the means by which repressions are

overcome in the therapeutic situation is through relentless disclosure of self to the therapist. When a patient is finally able to follow the fundamental rule in psychoanalysis and disclose everything which passes through his mind, he is generally shocked and dismayed to observe the breadth, depth, range and diversity of thoughts, memories and emotions which pass out of his "unconscious" into overt disclosure. Incidentally, by the time a person is that free to disclose in the presence of another human being, he has doubtless completed much of his therapeutic sequence.

Self-disclosure, then, appears to be one of the means by which a person engages in that elegant activity that we call real-self-being. But is real-self-being synonymous with healthy personality? Not in and of itself. I would say that real-self-being is a necessary but not a sufficient condition for healthy personality. It is in fact possible for a person to be much "nicer" socially when he is not being his real self than when he is his real self. But an individual's obnoxious and immoral real self can never grow in the direction of greater maturity until the person has become acquainted with it and begins to be it. Real-self-being produces consequences, which in accordance with well-known principles of behavior (Skinner 1953) produce changes in the real self. Thus, there can be no real growth of the self without real-self-being. Full disclosure of the self to at least one other significant human being appears to be one means by which a person discovers not only the breadth and depth of his needs and feelings but also the nature of his own self-affirmed values. There is no conflict between real-self-being and being an ethical or nice person, because for the average member of our society self-owned ethics are generally acquired during the process of growing up. All too often, however, the

self-owned ethics are buried under authoritarian morals (Fromm 1947).

If self-disclosure is one of the means by which healthy personality is both achieved and maintained, we can also note that such activities as loving, psychotherapy, counseling, teaching and nursing all are impossible of achievement without the disclosure of the client. It is through self-disclosure that an individual reveals to himself and to the other party just exactly who, what and where he is. Just as thermometers, sphygmomanometers, etc. disclose information about the real state of the body, self-disclosure reveals the real nature of the soul or self. Such information is vital in order to conduct intelligent evaluations. All I mean by evaluation is comparing how a person is with some concept of optimum. You never really discover how truly sick your psychotherapy patient is until he discloses himself utterly to you. You cannot help your client in vocational guidance until he has disclosed to you something of the impasse in which he finds himself. You cannot love your spouse or your child or your friend unless he has permitted you to know him and to know what he needs to move toward greater health and well-being. Nurses cannot nurse patients in any meaningful way unless they have permitted the patients to disclose their needs, wants, worries, anxieties and doubts. Teachers cannot be very helpful to their students until they have permitted the students to disclose how utterly ignorant and misinformed they are. Teachers cannot even provide helpful information to the students until they have permitted the students to disclose exactly what they are interested in.

I believe we should reserve the term interpersonal relationships to refer to transactions between "I and thou," (Buber 1937), between person and person, not role and

role. A truly personal relationship between two people involves disclosure of self, one to the other, in full and spontaneous honesty. The data that we have collected up to the present time (using very primitive data-collecting methods) have showed us some rather interesting phenomena. We found (Jourard and Lasakow 1958), for example, that women consistently are higher self-disclosers than men; they seem to have a greater capacity for establishing person-to-person relationships—interpersonal relationships—than men. This characteristic of women seems to be a socially-patterned phenomenon, which sociologists (Parsons and Bales 1955) refer to as the expressive role of women, in contradistinction to the instrumental role which men universally are obliged to adopt.

Men seem to be much more skilled at impersonal, instrumental role-playing. But public health officials, very concerned about the sex differential in mortality rates, have been wondering what it is about being a man, which makes males die younger than females. Here in Florida, Dr. Sowder, chief of the state health department, has been carrying on a long-term, multifaceted research program which he has termed "Project Fragile Male." Do you suppose that there is any connection whatsoever between the disclosure patterns of men and women and their differential death rates? I have already intimated that withholding self-disclosure seems to impose a certain stress on people. Maybe "being manly," whatever that means, is slow suicide!

I think there is a very general way of stating the relationship between self-disclosure and assorted values such as healthy personality, physical health, group effectiveness, successful marriage, effective teaching, effective nursing, etc. It is this: A person's self is known to be the immediate



determiner of his overt behavior. This is a paraphrase of the phenomenological point of view in psychology (Snygg and Combs 1949). Now if we want to understand anything, explain it, control it or predict it, it is helpful if we have available as much pertinent information as we possibly can. Self-disclosure provides a source of information which is relevant. This information has often been overlooked. Where it has not been overlooked it has often been misinterpreted by observers and practitioners through such devices as projection or attribution. It seems to be difficult for people to accept the fact that they do not know the very person whom they are confronting at any given moment. We all seem to assume that we are expert psychologists and that we know the other person, when in fact we have only constructed a more or less autistic concept of him in our mind.

If we are to learn more about man's self, then we must learn more about self-disclosure—its conditions, dimensions and consequences. Beginning evidence (Rogers 1958) shows that actively accepting, empathic, loving, non-punitive responses—in short, love—provides the optimum conditions under which man will disclose, or expose, his naked, quivering self to our gaze. It follows that if we would be helpful (or should I say human?) that we must grow to loving stature and learn, in Buber's terms, to confirm our fellow man in his very being. Probably this presumes that we must first confirm our own being.

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## FALSE SANCTUARY

I built a wall of time embodied stone  
Around my yard and in it there was sown  
Such flowers as no layman's eyes had seen  
Lawns that near surpassed the emerald's  
green.

I built the house by cautious rule and  
line  
To spaciousness that words could not define  
With no thing lacking from its foot to  
vane  
With teak from far ChowWan and rugs  
from Spain.

But in this beauty there was fallacy  
For I had built for but these eyes to see  
And yet I added (to complete it all)  
A lofty gate and spikes along the wall.

The search had ended. Solitude I'd found  
at last  
And hid the key that locked the gate, to  
prove it fast.  
Before retiring, with complacency  
Unto the bed no one could share with me.

With sleep I dreamed but in that dream  
of storm at sea  
A pounding surf of voices taunted: "Find  
the key!"  
Until in fright I woke to fight  
To fight the night that covered me.

I searched the room, the hall, the house,  
the yard.  
The flowers by their roots were pulled. I  
turned the sod,  
Until in final desperation at the gate  
I cling and watch the masses I had learned  
to hate.

Ah; but the masses who were "Mass" to me  
Are not the same when seen respectively  
They live and love and know the God I  
never knew  
And build the world, and fight for it, with  
better worlds in view.

The steel beneath my hand is cold  
As I recall a tale of old  
About another God-forsaken wall.  
Oh Lord of Jericho, might this one fall?

# Psychiatry in a small rural general hospital

In 1955, aided by a generous grant from the Commonwealth Fund, the Mary Imogene Bassett Hospital in Cooperstown, N. Y., activated a department of psychiatry. So far as could be learned from the literature at that time there was limited precedent for establishing a psychiatric practice in a rural community or for establishing psychiatric services in a small general hospital. A few papers about psychiatric practice in small communities had referred to communities of 25,000 to 50,000 people;

Cooperstown has 2,500. Bennett, Hargrove and Engle in their book, *The Practice of Psychiatry in General Hospitals*<sup>1</sup> included a foreword by Dr. Blain in which he says that no general hospital should be without a psychiatric service, but most of the book was devoted to descriptions of fairly large services in fairly large hospitals. In the last chapter of this book there is a statement to the effect that small cities can succeed in these efforts too, but the example given is Ogden, Utah, a city of 40,000 which had an ongoing ward of 20 psychiatric beds in a 200-bed general hospital. So, we began more with a wish to provide services than with ideas as to how these services might be provided.

A survey made in 1956 by Bush<sup>2</sup> revealed that 223 general hospitals in this country provided separate beds for psychiatric patients. A total of 581 general

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Dr. Adams is chief of professional education at Camarillo State Hospital in California.

<sup>1</sup> Bennett, Abram Elting, Eugene A. Hargrove and Bernice Engle, *The Practice of Psychiatry in General Hospitals*. Berkeley, University of California Press, 1956.

<sup>2</sup> Bush, C. K., "Growth of General Hospital Care of Psychiatric Patients," *American Journal of Psychiatry*, 113(June 1957), 1059-62.



hospitals reported that they accepted psychiatric patients in other than emergencies, but the report did not state how many of them provided only diagnostic or supportive facilities. The figure of almost 600 general hospitals accepting psychiatric patients looked pretty good until one read further and learned that this was less than 11% of all the general hospitals in the country, and a breakdown of the figures given indicated that those hospitals which did have psychiatric beds each had an average of over 10 beds reserved for psychiatric patients. Again these figures seem to indicate the lack of experience with psychiatric units in the size hospital ordinarily thought of as a community hospital.

I should tell you here a little about the Mary Imogene Bassett Hospital. There are 120 beds, including bassinets, divided into six nursing units, one each for pediatrics and obstetrics, one male and one female ward and two private or semi-private pavilions. At the present time, patients in these four latter units are not segregated at all according to services, although planned expansion may provide for primarily medical or surgical wards. There are about 25 members of the senior staff, all of whom are full-time salaried employees of the hospital with offices in the hospital building. A very active outpatient service is staffed by these same physicians. About 15 house officers are in residence, and the school of nursing of a nearby college uses the hospital as its primary clinical training facility. About 57% of the patients admitted to the hospital (3,716 in 1956) come from the county in which the hospital is located and another 35% come from adjacent counties.

Because of the teaching programs and considerable research activity, maintaining a balanced budget depends somewhat on

income from an endowment and special grants to the hospital, but the costs to the patients are about the same as those in other community hospitals in the vicinity.

The psychiatric outpatient work has not been strikingly different from that that might be seen in any private psychiatric practice. During three years about 700 new patients have been seen by the psychiatrist. Ordinarily, at any given time, two or three patients will be working in intensive psychotherapy, being seen three or four times a week over a considerable period of time. Four or five patients are being seen at weekly intervals and 20 or 30 patients are being seen at greater intervals. A psychiatric social worker joined the department after about 18 months, and he too has carried 15 to 20 hours of interview therapy each week.

Working in intensive psychotherapy with patients whom one encounters frequently in the daily life of the village has some complications but usually has not constituted a real obstacle for the well-motivated patient. Similarly, community gossip about who is seeing the psychiatrist has not, patients tell us, been a problem for them. The major difference is that in a sparsely populated area some outpatients travel very considerable distances, often in severe weather. This means that one must be fairly careful in evaluating or uncovering motivation, but the missed and cancelled appointment rate has not been high.

Caring for inpatients has followed less well defined lines. The first decision we had to make regarding inpatients was where to put them. From the outset, the construction and equipping of a psychiatric ward appeared impractical; the small hospital must maintain considerable flexibility, and it is not nearly so easy as in a large hospital to designate a bed as surgical or medical or psychiatric. If a psychiatric ward had been

built along the usual lines, this flexibility would not have been maintained; good public relations does not admit to bringing patients with gall bladder or coronary disease into an environment of locked doors, Chamberline screens and sharp counts. If we were going to have psychiatric patients and preserve conditions that might be found in most community hospitals, we would have to admit them, by and large, without segregation.

At the same time that we were doing this, Castelnovo-Tedesco<sup>3</sup> was having a similar experience on a women's ward in a military hospital in Alaska, and he has written of some of the advantages of such a practice. He felt that the psychiatric patients and their ward fellows, because of the lack of segregation, tended to accept the psychiatric illnesses more as medical illnesses. We have not usually found this to be the case, and we have not found it especially helpful when it did turn out to be the case. Comparisons between a psychotic episode and a broken leg can be carried just so far before they break down, and an attitude of waiting for time and the doctor to cure the psychiatric illness may sometimes impede the patient's participation in his own healing. Other patients are sharply aware that the psychiatric patients do get up, get dressed, go out for activities, see more of their doctors and generally disport themselves quite unlike usual hospital patients. These differences can sometimes be helpful to the psychiatric patient in an occupational therapy or role-taking kind of way. One schizophrenic girl did begin to regain some feeling of identity in mailing letters and filling water glasses

for other patients; another woman with an hysterical character structure and tremendous hunger for love seemed to begin to recover from a panic related to her not being able to gain affection sufficient for her tremendous needs when she became the angel of mercy in the ward.

The policy of admitting psychiatric patients to the medical and surgical wards has, however, been of great usefulness in getting families of patients to accept hospitalization for the patients. The family which has lived with an acutely psychotic patient for a week or two and is guilty about its unconscious wishes to be rid of the patient accepts this easy way out. With some help from the social worker, they seem more readily to accept the fact of the illness without being too separated from the patient. Despite the time-honored practice of sharp restriction of visitors to psychiatric wards, we have really very little evidence that visitors disturb our patients, and we suspect that this notion has taken most of its origin from the fact that visitors disturb hospital routine. Related to admission of patients to general wards is the fact that patients rarely refuse suggested treatments. That the family has been comfortable in visiting the patient in not unfamiliar surroundings has been related to the great ease with which many of our patients have returned to their homes after hospitalizations.

In 1955, when services began, chemical restraint was just coming into its own, but we did not find this adequate help for admitting disturbed patients to the general wards. Something of a prejudice in the psychiatrist against constructing a tight room two or three times almost caused the collapse of the whole program. The 48 hours required to bring the very active patient under the influence of a medication can panic the patients and personnel of a

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<sup>3</sup> Castelnovo-Tedesco, P., "Care of Female Psychiatric Patients, Including the Acutely Disturbed, on an Open Medical and Surgical Ward," *New England Journal of Medicine*, 257(October 17, 1957), 748-52.

ward. Moreover, of course, an episode of excitement may erupt with little previous warning, and a protection for the patient and his ward fellows and his attendants must be immediately available.

There is now one room equipped for handling disturbing patients. Interestingly, the availability of the room has much reassured hospital personnel, and requests that patients be moved to such a facility have decreased, it seems to me, since we have it. We purposely chose quite a large room, about 20 x 20. It is part of a nursing unit, and is regularly used as a 2-bed room when we do not have a disturbed patient in it, again maintaining the flexibility so necessary. We like the fact that it has no bath and patients must be taken out frequently. We like the fact that when the door is opened, the patient is not behind another locked door but is immediately in an environment where some social control is expected.

With this one room, taking all patients that seek admission, and with an average hospital census of around 80 patients, we have not had to ask that a patient be moved to another hospital because we could not handle his behavior. Before equipping this room, we had had to do this several times.

When we began to admit our psychiatric patients, the question of suicidal attempts was, of course, immediately raised. In this particular situation, happily, the hospital administration did not press about this, but the nursing personnel was very uneasy indeed. I shall mention this problem later. We have had only one suicidal attempt, almost surely brought on by the psychiatrist's insensitive response to the request of a schizophrenic man for a razor; there was plenty of evidence to show that he was hallucinating voices which instructed him to kill himself, but he was told that he could have his razor if he wanted it. We

continued to work with this man to a social recovery, but he became ill again a year later and finances required his being admitted to a state hospital, from which he has since been discharged.

Private psychiatrists in many places have, of course, been treating depressed patients with electroconvulsive therapy on private pavilions for some years with no rash of suicides, but very little has been said about this in the literature that reaches nurses and doctors. In keeping with the experience of other psychiatrists, these patients have given us little management difficulty. It is our impression that less regression is seen in the depressed patient who is kept off a psychiatric ward. It is our impression that the early improvement in the depressed patient treated with ECT is greater if the patient is kept in an unsegregated group. In this group we do find the comparison to other medical illnesses helpful to the patient in accepting the treatment about which he has heard so many horror stories; it is surprising to see how rapidly patients come to equate their shock therapy with irrigations or thorocenteses or, as one surgical patient asked us who had seen us come onto the ward to do ECT, why did some patients always sleep a while after their EKG's?

It was mentioned above that some of the nursing personnel were uneasy when we began to admit psychiatric patients to their floors, but it is hard to tell you just how uneasy they were. Our own eagerness to reassure them only made matters worse for some time; you can imagine that it helped matters not at all when a night nurse was told that she would be no more responsible if a psychiatric patient committed suicide than if a patient with a peptic ulcer bled to death. Then she knew that the suicide was a certainty.

The magnificent directress of nurses in



our hospital saved the day after several of these near misses. With little help from us, she quietly communicated to her staff that we were going to accept and treat these patients. She did us the kindness of telling us kindly but firmly when one of our patients was overstraining the tolerance of her staff.

With her we worked out what has been the answer to our nursing problems, and it cannot be sufficiently emphasized that a program like this cannot succeed unless such an answer can be found. In the same way that large amounts of space cannot be restricted to the use of one service, so too, but more critically, flexibility in the use of nursing personnel must be maintained. Even if there were funds for it, there would be little chance of getting and keeping psychiatric nurses in a village like ours, and we wouldn't know what to do with them during the times when we have one or no patients. What we did was to take a nurse who had worked for several years in the hospital. She was given head nurse status. Her duties are to take care of psychiatric patients throughout the hospital during the day shift. She assists with treatments. She does morning care for most psychiatric patients, arranges outings for them, escorts them downtown for shopping, and so on. Later a second nurse was brought in and made familiar with our routines. She too was kept on the daytime shift. If we have three patients or less, one of the nurses returns to general floor duty; if we have no psychiatric patients, both nurses do floor duty.

By having two nurses, some provision for week-end coverage can be made, but more importantly, the two nurses have an opportunity to discuss their experiences and keep their anxieties at tolerable levels. Our nurses have been encouraged to take coffee breaks with the other nurses on the floors,

to discuss with them what our attitudes and aims are with each patient, to leave quite full nurses' notes so that other nurses can know what is important to us. Also, we have urged them to assist in the nursing care of patients not on the psychiatric service but having periods of emotional storm. Frequently, when psychiatric consultation for a patient on another service has been requested, we have had our nurses do morning care for that patient, and in not a few cases the information they have obtained by taking their time and allowing the patient to talk has obviated the need for the psychiatrist's visit.

Our nurses constitute the most meaningful liaison we have been able to establish with the hospital community, and it is pleasant to be able to acknowledge my debt and gratitude to them. Nursing care during the evening and night is provided by the floor nurses, but it should be emphasized that this has gone far more smoothly since special nurses have worked during the day.

What sort of patients can we care for in this setting now? So far as I know, with the functions mentioned above now established, we do not have to exclude any patient. We aim at being an acute service, and we serve a community in which most of the people could not afford very long stays at \$20 per day even if we wanted it otherwise. Moreover, the hospital must meet the medical needs other than psychiatric of the community, and we would not be justified in tying up its beds for the care of chronically ill patients.

Patients in psychotherapy can be cared for during panic states. I have indicated that ECT is administered easily; we have a small cart with the stimulator, a suction machine, a small tank of oxygen with a mask and bag for positive pressure breathing, a laryngoscope and emergency drugs;

pentothal is administered to the patient in his own bed, the cart is rolled in, a seizure-free treatment is administered, and the patient recovers in his bed.

We have one room in the hospital in which we do physical treatments for outpatients, or for inpatients who are apt to recover noisily. We have used this room for the two patients who have been given insulin coma therapy; subcoma insulin is done on the wards. In this same room we do antabuse-alcohol tests, lumbar punctures, Funkenstein tests and the like, and, most importantly, we go there to have a cigarette and talk things over with our nurses. Since the psychiatrist's office is in the hospital building, most psychotherapeutic sessions are conducted there, but under other circumstances such a treatment room could easily have added a couple of chairs for this purpose.

Some of the advantages of such a program have been mentioned or implied; others are obvious. The ease with which patients and families accept hospitalization is quite impressive. Stigmatization is minimal. Although certainly it is sometimes highly therapeutic to allow a patient asylum—and we have several times recommended state hospital care to patients who wanted and could afford our services—we are also convinced that the period of disability for many psychiatric patients requiring hospitalization is decreased by allowing them to remain in familiar hospitals in their own communities. The community hospital is much more likely to be a part of familiar reality and less likely to encourage withdrawal from the healthy pressures to reality-testing which do exist.

The opportunity for non-psychiatric patients to see what happens during psychiatric hospitalization is surely as potent a device for freeing our work from too familiar prejudices and stigmata as most bro-

chures and lectures or television programs, and over a period of time a surprisingly large audience can be so reached. Not the least important members of this audience are our fellow professional workers.

We have done almost no lecturing. We have had no group sessions for nurses. We do have psychiatric rounds once each week in which one patient is discussed, attended mostly by resident and attending physicians and students. But mostly by precept we have been quite successful in disseminating some basic and important facts to non-psychiatric personnel about psychiatric illnesses. It is happy progress that many of the nurses who have gone through this learning process with us accept and work with acute but often very serious psychiatric symptoms occurring in their patients. It is far more than semantic progress that we hear much around the hospital about patients who are hallucinating or illusional or deeply depressed, but we hear very rarely now of patients who are out in left field or flipped or crazy. We get far more requests from nurses for orientation regarding attitudes than for sedative orders. After the first appalled month or so, our house staff asks far more for opinion and help in management than for transfer. Our senior staff seems much less to expect us to take over the lives and all the problems of the patients they refer, but sees us much more as doctors oriented to disease, diagnosing by symptoms, treating from a therapeutic armamentarium far broader than just "taking him off my hands," and aiming at restoration of function.

The psychiatrist too, stripped of the protection of isolation in a segregated ward and associating with physicians who do not speak his jargon, finds that he must re-examine much that is traditional. Differences between physical and psychological diseases do not disappear at all, but the

biological substratum on which they both exist comes much more to the fore. In the privacy of our own councils, we can easily forget that chronic brain syndrome doesn't really mean much in many of its usages, but in talking to a medical house officer one does well to be prepared to discuss why so many of our patients don't show the arteriosclerosis at the autopsy table.

Whether psychiatry and physical medicine are blood sisters, or should be, I will not discuss here. I do know that, actually living in the same house as they must under the circumstances I am describing, they must learn more to speak the same language or else return to their separate quarters. I think my associates have learned a great deal in the last three years about what a psychiatrist—or at least one of them—does and does not do. I know that I have learned a very great deal indeed about what it is like to be a doctor and treat a patient.

There are, of course, disadvantages in this sort of program. The greatest one is professional isolation. The small community may be able to support one but not two psychiatrists. If he is hospitalizing patients, he may find that he has tied himself down severely and that no one is available to provide a continuum in his patients' treatment while he takes vacations or even a weekend. Our specialty is sufficiently non-medical and the personal demands on the psychiatrist functioning as such are sufficiently great that all but the most mature of us need opportunity to talk about our work with professional confreres. Similarly, some decisions that the psychiatrist in a general psychiatric practice must occasionally make have very far-reaching consequences in a patient's life, and having to do this regularly without the benefit of consultation increases the personal strain.

Second, as I have already indicated, at our present state of knowledge I do not

think it is wise or sound to go too far in indicating to the patient that his illness is a purely medical one. Third, one disturbed patient in a general medical and surgical ward for even a short period of time can undo a lot of good public relations work. Fourth, while there are advantages in having close contact with nonpsychiatric physicians, a potential disadvantage is that the kind of hospital care we have offered may look too simple to the casual observer, and other physicians not adequately trained may be too much encouraged to proceed with what they call a common-sense psychiatry that is really not based on what scientific foundations we do have. Fifth, such services as these are not intended to provide complete psychiatric care. The general hospital is not the place to care for chronically ill patients. The stimulation of the general hospital may be too much for some acutely ill patients. If one proposes, however, to provide fairly over-all psychiatric care, some of these patients who should be cared for elsewhere will have to be admitted before one knows that they should not have been.

Our therapeutic successes have, I believe, been quite adequate to justify the existence of our program. The total number of patients treated is not great enough to lend itself to statistical analysis. In three years we have admitted 133 patients. We know that 13 of the patients who have been hospitalized in Cooperstown have had further psychiatric hospital care elsewhere, many of these on our specific recommendation. We know that a few patients whom we for one reason or another did not admit have been successfully hospitalized and treated elsewhere. Our aim with our hospitalized patients has been to restore function to the point that the patient can return to his community, so that we also know that we have successfully achieved symptomatic relief for many of our patients without achiev-



ing the basic reorganization for which we might have hoped. This, of course, is the same as is true in the large majority of psychiatric hospitals.

Psychiatric care in general hospitals is expanding and is going to continue to expand. I have not here belabored the obvious justifications for this movement; these have been adequately and repeatedly described elsewhere, but mostly regarding large hospitals. I have attempted to tell you of some of our experiences which indicate that these services can be provided in the small community and in the small hospital, if the psychiatrist is willing to tailor his program to the needs of the specific hospital community in which he wants to

practice and live. I know now that we cannot do in Cooperstown what can be done in Ogden, Utah, but I also have learned that what Cooperstown or any other community needs is not necessarily the same as what Ogden, Utah, needs. There are important differences between our hospital and many community hospitals. There are enough similarities that we feel we can say that smaller communities and hospitals not only should, but can, have psychiatric services.

#### ACKNOWLEDGMENT

Grateful acknowledgment is made to the Commonwealth Fund for support of the project reported here.

# Suicide

*Magna civitas, magna solitudo*

## PART I: DEMOGRAPHY OF SUICIDE

Once every minute, or perhaps even more often, someone in the United States either kills himself or tries to do so. Fifty or sixty times each day, day in and day out, people succeed in these attempts. This means that somewhere between 16,000 and 20,000 people suicide each year. In 1955 the suicide rate was 10.2 per 100,000 population, thus ranking suicide among the leading dozen killers in the United States (see Table 1).

Actually the rate is much higher. A substantial number of deaths due to suicide are not so recorded on death certificates because of religious, social or moral stigma. In this respect suicide shares the dubious honor of

secrecy with alcoholism, mental illness and venereal disease. Many deaths of adults due to the ingestion of poisons, particularly when large numbers of barbiturate pills are taken alone or in combination with alcohol, are classified as accidental when in reality they are intentional. Many deaths due to gas poisoning, whether in the garage or over the kitchen range, similarly are listed as accidental when they, too, should fall in the intentional column. To this we can add many more—the slow suicide of chronic alcoholism, the savage suicide of far too many automobile accidents, and, increasingly, the subtle suicide of overdosing with tranquilizers. Together these would raise the total to the much more realistic figure of 50,000 to 60,000 cases per year.

While cases and rates represent the final catastrophe, they tell only part of the story of suicide. The magnitude of this story must be measured also in the *attempts* at suicide made each year. Accurate figures

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Dr. Hirsh is associate professor of preventive and environmental medicine at the Albert Einstein College of Medicine, Yeshiva University, New York. Parts 2, 3 and 4 of his 4-part study of suicide will appear in the January and April 1960 numbers of *Mental Hygiene*.

TABLE 1

*Leading causes of death in the United States;  
death rates<sup>1</sup> for selected diseases, 1955<sup>2</sup>*

1. Diseases of the heart	355.8
2. Malignant neoplasms	146.5
3. Vascular lesions affecting the central nervous system	106.0
4. Accidents	56.9
5. Certain diseases of early infancy	39.0
6. Influenza and pneumonia except pneumonia of newborn	27.1
7. Generalized arteriosclerosis	19.8
8. Diabetes mellitus	15.5
9. Congenital malformations	12.5
10. Cirrhosis of the liver	10.2
11. Suicide	10.2 (16,760 deaths)

<sup>1</sup> Per 100,000 population.

<sup>2</sup> Vital Statistics, Special Reports, National Summaries, Vol. 46, No. 5, May 6, 1957.

TABLE 2

*Suicide and self-inflicted injury; mortality rate<sup>1</sup>  
by sex, age and race, U. S., 1955<sup>2</sup>*

AGE GROUPS	WHITE AND NON-WHITE		WHITE		NON-WHITE	
	M	F	M	F	M	F
All ages	16.0	4.6	17.2	4.9	6.1	1.5
10-14	.4	.2	.4	.2	.2	—
15-19	3.9	1.3	3.9	1.4	3.7	1.0
20-24	8.7	2.6	8.6	2.6	9.2	2.7
25-29	12.2	3.8	12.6	3.6	8.4	3.0
30-34	12.6	5.4	12.8	5.8	10.6	2.6
35-39	15.8	5.4	16.4	5.8	9.4	2.0
40-44	22.0	6.8	23.2	7.4	10.9	1.5
45-49	26.5	9.0	28.3	9.6	9.3	2.8
50-54	33.4	10.1	35.7	10.9	11.7	2.6
55-59	39.0	9.9	41.5	10.7	12.7	1.5
60-64	42.5	9.7	45.0	10.1	12.6	4.0
65-69	44.3	10.2	46.7	10.7	12.2	3.3
70-74	44.8	8.0	47.0	8.3	13.4	3.0
75-79	51.1	8.0	54.2	8.4	12.0	2.0
80-84	55.2	8.1	58.2	8.6	14.6	—
85 and over	56.4	6.6	61.2	7.2	12.5	—

<sup>1</sup> Per 100,000 population.

<sup>2</sup> From *Mortality Rate for Selected Causes, Annual Epidemiological and Vital Statistics*. Geneva, World Health Organization, July 1958.



TABLE 3

*Suicides<sup>1</sup> in selected countries,  
15 to 19 years of age, by sex<sup>2</sup>*

COUNTRY	YEARS	MALES	FEMALES
Japan	1951-1953	26.1	18.7
Switzerland	1952-1954	16.9	6.4
Finland	1952-1954	12.3	2.6
German Federal Republic	1952-1954	12.1	6.8
Austria	1952-1954	11.7	8.1
Union South Africa (European population only)	1951-1953	9.7	2.8
Denmark	1952-1954	8.3	5.9
Chile	1950-1951	7.6	4.3
Portugal	1947-1949	6.9	6.0
Australia	1951-1953	6.2	1.9
Sweden	1951-1953	6.0	3.3
New Zealand (without Maoris)	1952-1954	5.2	0.5
France	1952-1954	4.4	2.4
United States	1951-1953	3.9	1.6
Spain	1951-1953	3.8	2.0
Canada	1952-1954	3.8	0.7
Italy	1951-1953	2.9	3.3
England and Wales	1952-1954	2.9	1.1
Netherlands	1952-1954	2.3	0.8
Norway	1952-1954	2.0	1.0
Scotland	1952-1954	1.9	0.4
Ireland	1952-1954	0.6	1.1

<sup>1</sup> Per 100,000 population.

<sup>2</sup> From *Epidemiological and Vital Statistics Report, Mortality from Suicide*, Geneva, World Health Organization, 9 (1956), 243.

here, too, are unavailable but estimates based on hospital and police records indicate that at least 5 and as many as 60 attempts are made for every successful one completed. These attempts—costly, cruel and tragic—are the real measure of the specter of suicide which touches and haunts millions of Americans each year.

The demography of suicide, though it is incomplete, suggests that the act is alien to no single age-group. It occurs occasionally

even in the very young—indeed, hardly before life has really begun. In the United States it rises in a steady curve from less than 1 per 100,000 population in the age-group 10-14 to 4 per 100,000 among white males in the late teens (see Table 2). Suicide was the second most frequent cause of death in the Yale University student body from 1925 to 1955 (1). But this situation is by no means unique to New Haven. An earlier report (2) covering the period from

1925 to 1935 listed suicide as the third leading cause of death in a number of colleges throughout the country.

A similarly high rate of suicide for students in the older English universities was recently reported (3). The commonest cause of undergraduate deaths during a 10-year period following World War II was accident, followed closely by suicide. At Oxford, for example, suicide was responsible for 27% of undergraduate deaths, which is estimated to be 11 times that of a similar group in the general population. At Cambridge the rate for white undergraduates, male and female, was 17.8 per

100,000, nearly three times that for the population as a whole of England and Wales.

Startling though they may be, these facts pale before the record of suicides in the young in European and certain Far Eastern countries, notably Japan (see Table 3). In Japan, ironically, the second most frequent cause of deaths after suicide in the age-group 15-24 is accidents.

In the United States the suicide rate rises steadily from its relatively low point in youth to an impressive peak of over 50 per 100,000 population in age-groups over 75. Data from current studies in the city of New York bear this out (see Chart 1).

CHART 1

# SUICIDES IN THE CITY OF NEW YORK<sup>1</sup> OVER A THIRTY YEAR PERIOD (1925-54): According to age and sex.

<sup>1</sup>Based on Medical Examiner's Records.

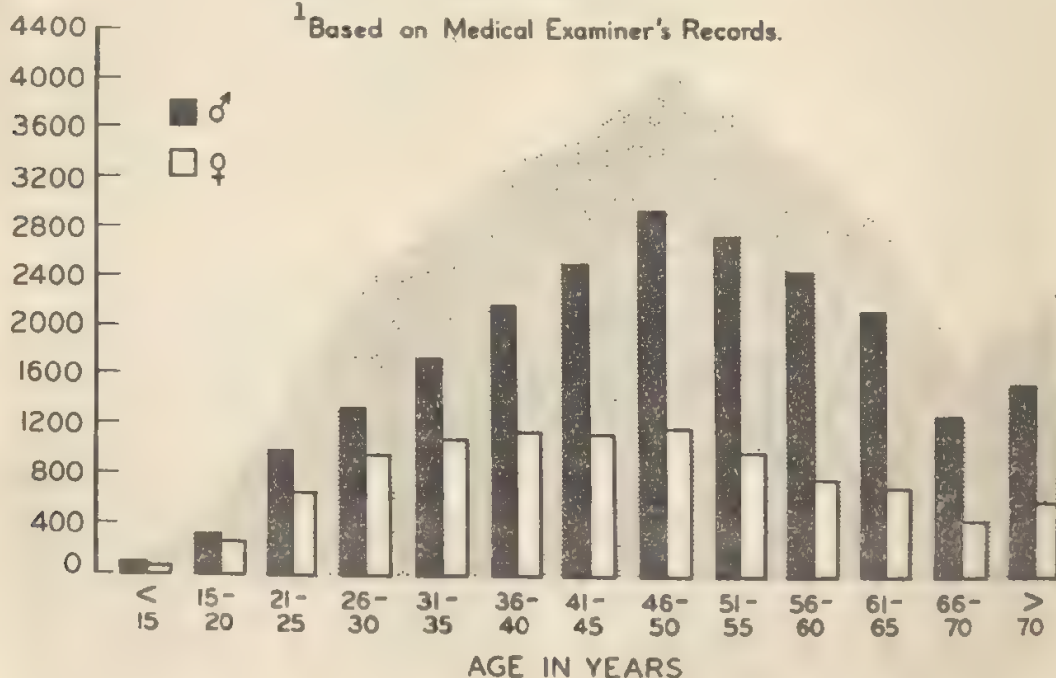


TABLE 4  
*Ratio of male:female suicides in  
 certain selected countries,  
 1901 and 1954*

		1901	1954
Predominantly Catholic	France	-	3.5:1
	Ireland	4:1	3.5:1
	Italy	4:1	3:1
	Portugal	2:1	3:1
	Spain	4:1	4:1
Predominantly Protestant	Germany	4:1	2:1
	Netherlands	3:1	2:1
	Norway	6:1	5:1
	United Kingdom	3:1	1.5:1
	U. S. A.	3:1	4:1
Buddhist	Japan	1.5:1	1.5:1

Here at home the male:female suicide ratio is approximately 4:1 but is much higher at the older ages. While similar male:female suicide ratios occur in many other countries (see Table 4) it must be said to their dubious credit in this macabre regard that women make more suicidal attempts than men.

Explanations of the differential in male:female suicide rates have been sought primarily in the stress situations inherent in the more demanding social and economic roles of the male. Without underestimating these factors, another possible answer may be in sex-specific patterns of suiciding. The fact that fewer women than men successfully suicide, despite far more frequent attempts, may be found at least in part in the methods used. Men tend to use more precipitous, more action-involved, more lethal agents and methods than women (see Part 2 of this study: *Methods and Fashions of Suicide*).

In those societies where women have status and role positions inferior to those of men, female suicide rates are generally high primarily because theirs is a hard, unrewarding and often intolerable lot. This is particularly notable in Far Eastern countries and certain agricultural countries in Europe.

With increasing industrialization came increasing emancipation of women and improvements both in their role and status. With these changes, in Europe particularly, successful suiciding in women became far less frequent than among their male counterparts.

From the stressful factors associated with male suicides it may be conjectured that as women become still more emancipated, increasingly independent and inevitably competitive with men, their suicide rates may become more comparable with those of men, whose suiciding often reflects frustration or failure in achievement, reduction or loss in status and role.

There is a similar racial ratio for suicides. In the United States the white:non-white suicide ratio is 4:1. The ratio of whites to Negroes is 3:1 (4).

For all that its critics may direct against it, marriage, according to most reports on this subject, neither predisposes to, nor precipitates, suicide. Rather, in tending to encourage externalization rather than internalization of aggressions it may motivate homicide but not suicide! These studies indicate that the rate for married people is generally lower than that for the single, widowed or divorced. It is highest for the divorced. It is higher for the widowed than for single persons up to the age of 35. Thereafter the pattern reverses itself, suggesting that older widowed persons have set up in their children, friends and relatives a network of relationships, like the compensatory collateral circulation in coro-



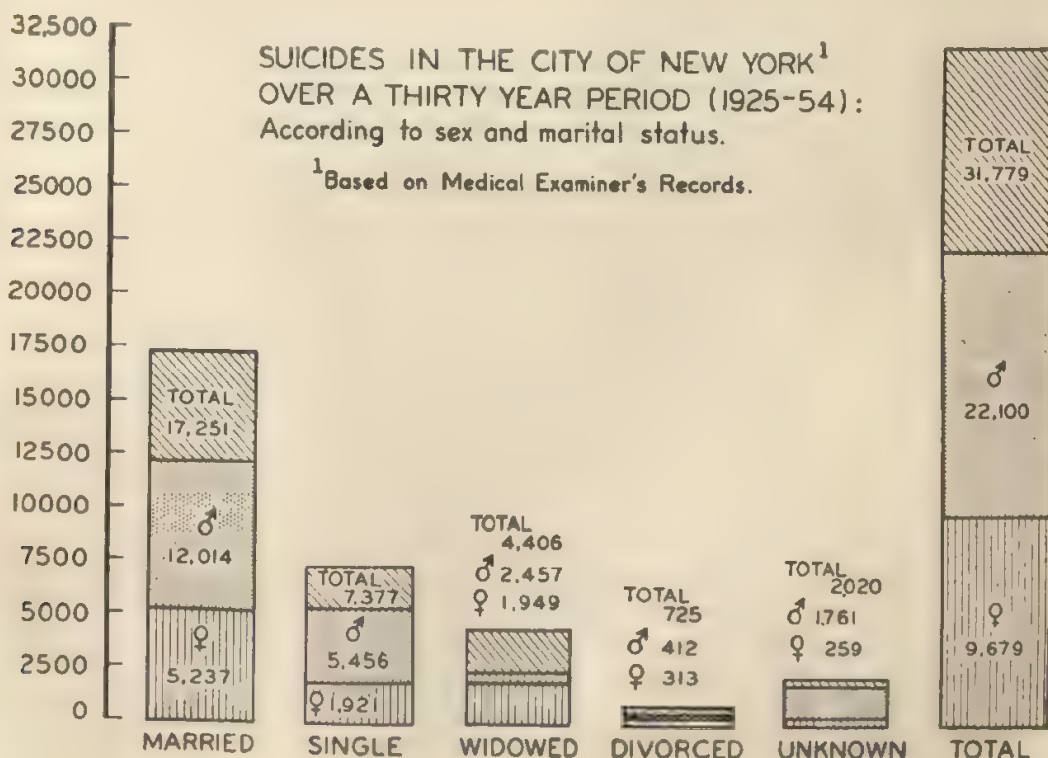
nary disease, which makes life possible. The single person in the older years—to extend this analogy one more step—like the uncompensated diseased heart, is often hopelessly and tragically alone, and it is the tragedy of this aloneness which perhaps more than any other single factor predisposes to suicide.

Sainsbury in his study of suicide in London (5) and the author in his current series of studies of suicide in New York (6, 7, 8) presently offer a minority view that the suicide rate among the married is not quite so low as has been reported previously (see Chart 2). It may be that these data are skewed largely because of the age factor. With their further elaboration, which is currently in process, it may be that these

rates for married people will assume the position more generally reported.

When what the social scientists call the relational systems generally are weakened or if they have not been established or strengthened the suicide rate tends to rise. This principle expresses itself in another dimension. In cities where there is a relative lack of meaningful human contacts and relationships—as compared with rural areas where ties of family, friends and church are so much stronger—suicide rates are higher. In fact, it may be said that urbanization seems to be a factor in suicide. The city confers anonymity and freedom from controls. An individual's status is reflected largely and too often by what he owns, not who he is.

CHART 2



The extent to which city life, with its lack of internal restraints and its weakened relational systems, tends to encourage all sorts of antisocial action has been reported in a series of sociological and psychological studies over the last quarter of a century. Shaw and his associates (9), in a study of delinquency in Chicago, found that delinquency increased with poverty and, to take one economic factor alone, diminished with home ownership. The broad conclusion they drew was that communities by and large had a direct, causal relationship to delinquency. Poor neighborhoods generally have an active criminal tradition, and as such tend to foster delinquency. This point of view was confirmed by Burt (10) in his study of the problem of delinquency in London.

Faris and Dunham (11) in their study of the ecology of mental disorder in Chicago found the lowest rates in neighborhoods of greatest social stability and the highest rates in rooming house districts, slums and other areas inhabited by those generally underprivileged groups—the foreign born, Negroes and transients. In general, these findings have been corroborated by Schroeder (12) in his study of Peoria. To be sure, there have been criticisms of the putative cause-and-effect relationships of these studies, the central one of which is that low status neighborhoods tend to attract antisocial and mentally disturbed individuals, not necessarily to create them. These criticisms notwithstanding, there are sufficiently provocative aspects to these data to give pause for thought not only in their own right but as they have some relevance for the ecology of suicide. Cavan's (4) study of suicide in Chicago indicated that the communities with the highest rates had shifting populations living in rooming houses and cheap hotels. Restless, impersonal, run-down or impoverished neighborhoods,

whether they are causally responsible for them or not, harbor people who have higher rates of divorce, alcoholism, drug addiction and suicide. These findings have been confirmed by other investigators, notably Schmid (13, 14, 15) in Minneapolis and Seattle, Faris (16) in Providence and Sainsbury (5) in London.

These various studies may be summarized by the statistical observation that suicide rates fall steadily from a high point in cities of over 100,000 to a low point in rural areas.

The city is only one of many relational systems bearing upon suicide. Economic and occupational status are two other prominent ones. Statistician Dublin (17), sociologist Gillin (18) and psychiatrist Sainsbury (5) independently arrived at the same conclusions for suicide—namely, that the rates are highest in the higher and lower occupational status groups and lowest in the middle occupational status groups.

Thus, one might infer that wealth at one end of the economic scale and poverty at the other predispose to suicide. This, however, has not been supported by the many studies of attempted suicides. Rather, it has been suggested by the second principle of Sainsbury (5), adducing from these studies, that mobility—not only spatially but also upwards or downwards from class to class or from occupation to occupation—and subsequent isolation from, or cohesion in, the community are far more significant factors in causality. He has deduced "that indigenous poverty does not foster suicide. On the contrary, the suicide rate tends to increase with social status. On the other hand, poverty befalling those used to a better standard of living is a burden badly tolerated, and a factor predisposing to suicide, secondary poverty of this kind would account for the rise in the suicide rate in the upper occupational classes during the

economic depression . . . , and the discrepant finding that the incidence of suicides living in poverty is greater when the suicide's actual economic level at the time of death is the criterion, rather than the economic status that might be inferred from occupation and neighborhood."

Serious physical illness is often another factor associated with suicides. Cavan (4), Andics (19) and others have reported a range of incidences of illness in suicides. But the extent to which these are contributory to the suiciding process has yet to be accurately ascertained. Illness itself is tolerable, apparently, judging primarily from studies of attempted suicide. Its effects—incapacitation, separation from the community and loss of work—are what make illness appear to be intolerable and hence causal in the suicide. Thus it may be that pain from neoplastic disease, for example, may be far less of a precipitant to suicide than the isolating effect of the disease—the disability and the separation from the family through hospitalization.

A number of psychiatric studies similarly point up the fact that suicides are generally disturbed persons. Despite the composite picture of the attempted suicide as an immature, egocentric, solitary individual, apparently unable to establish or maintain meaningful relationships and burdened with aggressive behavior which, when not externalized, tends to be turned inwardly, mental illness as a *sine qua non* to suicide is a sheer pat-ism. Many workers, whatever their discipline orientation, feel that much more work has to be done before a direct causal relationship of mental disorder to suicide can be established.

The meaning of relational systems may be seen also with reference to religion. The notion is generally held that religion serves as a prophylaxis against suicide. The more formal and binding the religious ties and

practices the less likely, is the belief, that its faithful will ever commit suicide. Under these circumstances one would expect that Catholics would have the lowest suicide rates and Unitarians, Reformed Jews and Ethical Culturists the highest. The one with its strict canons imposes severe injunctions and penalties against this most mortal of sins; the others are far less doctrinaire on this form of *exitus*. Actually, many predominantly Catholic countries have had a consistently low suicide rate with little change over the last fifty years. Yet Spain, during this same period, has tripled its suicide rate. It would be interesting to know the suicide record of Israel since its founding, where strong group identity, an anti-suicide factor in itself, is found in combination with relative freedom from orthodoxy. But even in the absence of such information it appears that Jews tend to be low man on the totem pole of suicide. It may be that their centuries-old struggle for individual and collective survival has made unnecessary formal prohibitions against suicide.

Business cycles, wars, the moon and scores of other factors have been casually or systematically studied in relationship to suicide. But none has quite the fascination or potentially has as significant meaning as has weather in relationship to suicide.

Throughout history, weather, as weather, has been associated with states of physical and emotional well-being. In the temperate zone, the sunny, cloudless, brisk, relatively humidity-free day generally activates the sparkle in people. The dull grayness of fall and winter days, contrariwise, has a characteristically depressing effect. In the tropics the insistent monotony of cloudless days and searing sun have been known to wear some people into a state of lethargy and hopelessness and agitate others to the point of mania.



Alterations in bodily state, ranging from mild discomfort and indisposition to frank disease, have been observed during changes in weather conditions. Colds and other upper respiratory complaints, aching rheumatic joints, nagging scars from operations or old wounds and amputation stumps are concomitants of the falling barometer. The *chamsins*, those hot, east, sand-laden desert winds of the Arabs which blow out of North Africa and the Middle East, and the *siroccos* and *mistrals* blowing across the Mediterranean into France and Italy not only dry out the nasopharynx and irritate the conjunctiva, thereby setting the stage for upper respiratory and eye infections, but with their unremitting quality create serious disturbances of mood and outlook in many people, healthy or emotionally disquieted.

It was not only the searing sun but the violent *mistrals* of the Midi which drove an already tortured Van Gogh to his death. Switzerland, too, has its particular wind, the *Föhn*, which, unlike the sirocco, is hot and humid, gathering moisture as it crosses the Alps from Italy. An increase in crimes of all sorts—homicides in particular and suicides—follows in its wake. The courts in Switzerland and Germany take this into account in dealing with cases associated with this wind. In our own west (Colorado) there is a wind much like the *Föhn*, called the chinook by the Indians.

"Shifts in weather are often accompanied with marked changes in mood. With the pressure falling and the temperature rising many people are afflicted with a feeling of futility," according to one expert. "In children this takes the form of increased irritability, a restlessness and petulance. . . . Adults . . . are also more quarrelsome and fault-finding, with a tendency to a pessimistic viewpoint toward all matters. . . ." (20). Take then on such days the child in

his agitation and the *vieux* in his depression, the one spurred by spite, tortured by guilt, overcome by loss, the other hopelessly lost in his aloneness, living out as he sees his final days without meaning, warmth or purpose—and it is understandable that suicide rates should be distinctly higher then than at other times.

Considered by themselves these demographic data are statistical entities and oddities. At best they are only clues to suicide. But in their dynamic interrelationships they take on a meaning in depth, as we shall see in due course.

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MORRIS WEINSTEIN, Ed.D.

F. D. McCANDLESS, M.D.

## Empathic communication and anxiety in medical students

A current phase of medical education concerns the attempt to provide a type of training that will sensitize the medical student to the "humanistic" elements in the doctor-patient relationship. Increasing emphasis is being placed upon those issues, other than diagnosis and treatment, which are important in maintaining a sound relationship with the patient.

This report is part of a program aimed at an evaluation of a comprehensive family care program on affective aspects of student growth (1, 2, 3). Three areas of student involvement are under study: the degree of empathic communication, the degree of anxiety about illness, and the degree of

adequacy, as these relate to medical care.

Two suppositions are being investigated. The first is that professional empathic communication is a function of personality and is not particularly influenced by medical school curricula. Thus there should not be differences in this area between first-year and third-year students nor should there be differences between third-year students exposed to differing curricula.

The second hypothesis is that anxiety in a student's perception of illness is influenced by the extent of his medical knowledge, and also that the student's concept of his adequacy in the sickroom is a function of time spent in medical school.

### PROCEDURE

The population studied consisted of an entire freshman class, comprising 64 students, and a third year class of 50 students. All subjects were evaluated by projective

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Both authors are on the staff of the Albany Medical College of Union University. Dr. Weinstein is an assistant professor of psychology and of community health and Dr. McCandless is an associate professor of psychiatry and an assistant professor of community health.



techniques at the beginning and at the close of the school year, a period of eight months elapsing.

The freshmen took the usual preclinical courses. This group was included as a baseline of comparison against the more advanced students. If attitudes are due to personality primarily then there should be no significant difference between groups. The third-year students were divided into a control and experimental group. Experimental subjects were selected on the basis of stratified random sampling. Stratification was made according to grade point average achieved during the first two years of medical school. This was done so that differences related to scholastic achievement would be eliminated. The control group was exposed to the conventional third-year curriculum, which at this school is primarily centered on clerkships in the outpatient department. The experimental group was exposed to the same curriculum. In addition, they participated in the comprehensive family care program, which was substituted for a 66-hour course in public health.

Each experimental student was assigned the role of family physician to one family for a 9-month period. Duties were those of a general practitioner and included home visits, conferences with community agencies, and individual meetings with the family care staff. Students also participated with the staff bi-weekly in small student-oriented seminars. The family care staff was comprised of the chairman of the department of community health, who acted as group leader and coordinator of the project, an internist, a social worker, a public health nurse, a pediatrician, a psychiatrist and a psychologist.

#### METHOD OF EVALUATION

Several projective tests are being evolved in this program as a means of exploring

relevant attitudes. The findings reported here are derived from the sickroom situation test, an experimental procedure which is still in preliminary form. It is based upon a semistructured thematic apperception projective technique. This test comprises a slide of a sickroom with a doctor talking to a mother, and a multiple-choice response sheet. After instructions have been given, the picture is flashed on a screen and the students are told to select from multiple-choice items those which they consider best describes what is happening in the picture.<sup>1</sup>

Interpretation of responses is made on the basis of weighted scores. Responses are graded so that findings will be objective, and quantitative analysis can then be carried out. There are four major response categories: Empathic communication, anxiety, adequacy and the over-all self-concept regarding the sickroom situation. Briefly, the rationale is:

*Empathic Communication:* Empathy is defined as "mental entering into the feeling or spirit of a person; appreciative perception or understanding." Empathy score is determined by relating the degree of coincidence between the student's concept of how the mother feels and the issue with which the doctor is concerned. For example, a highly empathic score would be obtained by the student who sees the mother as "worried about her adequacy in following instructions" and the physician as perceiving that "the mother's anxiety hampers understanding of doctor's instructions." An unempathic score would be obtained if the student seeing the same concern in the mother perceived the doctor as preoccupied with "the correctness of his diagnosis."

<sup>1</sup> McCandless, F. D. and M. Weinstein, "Relation of Student Attitude Changes to Teaching Techniques," *Journal of Medical Education*, 31(1956), 47.

*Anxiety:* Experienced physicians perceived most illnesses in this picture as of a minor nature and something easy to handle, rather than as emergent problems of life or death. Therefore, it is postulated that the gravity with which illness is apperceived in the picture is a function of his inexperience and/or apprehension.

*Adequacy* is scored on the basis of what the student sees the doctor doing after handling the medical problem.

The *Gestalt* score comprises the total of all the sub-scores and is therefore a composite of over-all perception of the sickroom situation.

#### VALIDITY

The intangibility of the emotional factors being explored has necessitated validation through the use of clinical appraisal of subjects by several experienced judges. Six judges—members of the departments of psychiatry and pediatrics of the medical college—were used. They were asked to observe several groups of students rotating through the departments and to evaluate them in specific areas.

Twenty-three students were randomly selected during a 6-month period. The students were tested at the termination of their assignment. The consensus of the judges for each student was then compared with the test scores. Correlation between judges' opinions and students response in the three test areas are significant on the 2% level or below when Yates correction is applied. Further extensive validation is of course necessary.

#### RESULTS

At the outset, the family care, the regular curriculum and the freshman groups were similar in all the subtest areas but one.

This exception was in the gravity or anxiety with which the illness situation was approached. Here the freshman (baseline) group was significantly more anxious than the third-year group.

The freshman *Gestalt* score is no different before and after the first-year experience. Patient-oriented perceptions have not changed. The primary characteristic of this group is that these students are not involved in clinical work and do not come into contact with patients. The functions measured on the test therefore do not change appreciably as a result of the first year in this medical school curriculum. Neither do the control students improve significantly on the basis of their hospital work. This is in contrast to the growth reflected in the *Gestalt* score of those students who have had, in addition, the family care experience.

When the three groups are compared at the conclusion of the school year, there becomes apparent a noteworthy shift in the empathy area. The level of first- and third-year groups is similar at the outset and also at the end of the year in empathic communications. When the family care group is compared with the others, however, it is found that there is an increase in empathy in the family care group and a decrease in the control group. The difference between them is significant at the 5% level. The freshmen do not fluctuate significantly, although they do manifest some slight decrease in empathy. Thus in the third year the family care students evidenced an increased ability for empathic communication while the control students declined in this respect (Table 1).

In the area of anxiety, as measured by the illness choice, the family care and control groups showed no significant difference at the outset or at the end of the experimental period. However, the difference between freshmen and juniors became even greater

TABLE 1

Comparison of means in all groups: after

AREA	TOTAL		SIGNIF.	FAMILY CARE	CONTROL	T = .05 SIGNIF.
	THIRD YEAR	FIRST YEAR				
Anxiety	2.78	3.35	S	2.75	2.74	NS
Empathy	2.75	2.90	NS	2.00	3.20	S*
Resolution	0.51	0.50	NS	0.60	0.45	NS
Consistency	1.20	1.30	NS	1.10	1.26	NS
Adequacy	1.32	1.70	S	1.25	1.36	NS
Gestalt	8.58	9.68	S	7.55	9.27	S**

\* Family care also significantly more favorable than first year.

\*\* It is noteworthy that the gap between family care and control has widened not only because family care is more favorable, but because control has declined to a less empathic trend.

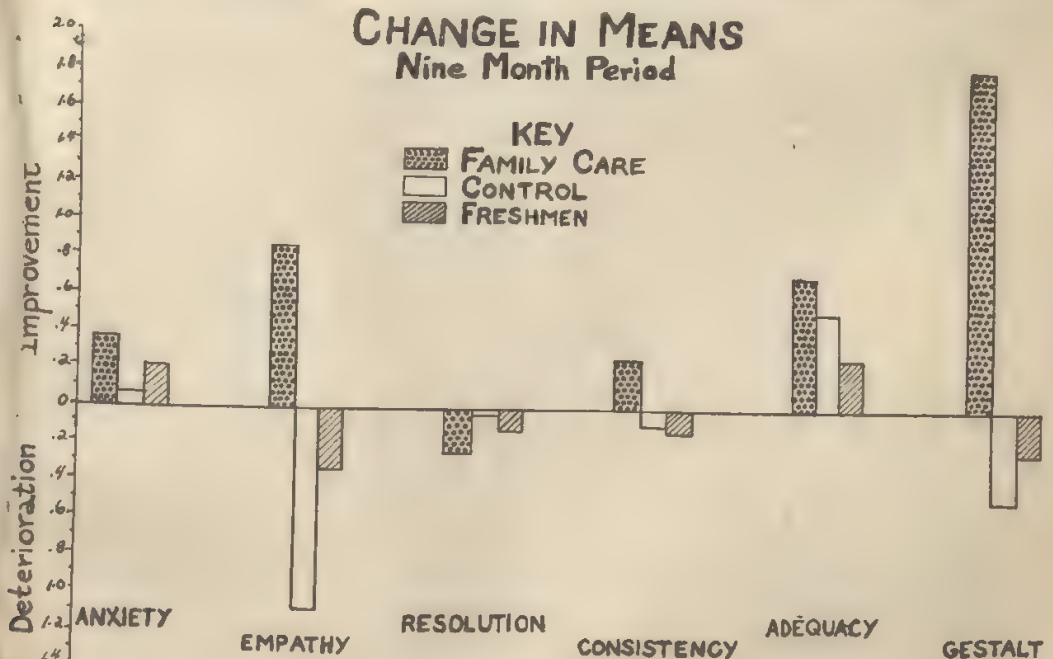
at the end of the year. This would indicate that the gap between freshmen and third-year students is ascribable to factors other than chance and is probably a function of

clinical experience common to both experimental and standard curriculum.

In the area of adequacy the family care and control groups are similar to the fresh-

TABLE 2

Changes in mean value of test responses for all groups over a 9-month period





men at the outset. At the end of the year the freshmen remain the same and both third-year groups have improved significantly from their original level (Table 1).

The degree and direction of the changes in all areas for the three groups are summarized in Table 2. It should be pointed out that the difference in empathic communication is due to improvement in the family care students as well as a decline in this function in the other groups. The marked gain in the *Gestalt* score of the experimental group reflects not only the significant improvement in empathy scores but also minor trends that, taken alone, are not significant. Thus there may be greater intangible benefits than are apparent from isolated factor scores.

## DISCUSSION

The null hypothesis was predicated on the concept that empathic communication is essentially a function of personality not appreciably influenced by medical school training. The findings indicate that first- and third-year students do indeed generally share similar concepts of empathic communication. However, there was a significant difference in the responses of the experimental group as compared to those of all other students at the conclusion of the year's experience. Although the variables of both close longitudinal doctor-patient relationship and student-oriented conferences differentiated the experimental curriculum, it is outside the scope of this study to evaluate the exact contributions of each.

As Table 2 indicates, the gain by family care is significant only because there is an increase in empathic communication in this group and a decline in the controls. By themselves these changes are not significant, but when both divergent trends are considered the difference becomes noteworthy. It is interesting that the negative

change in the controls represents a downward trend in this conventional third-year group. This tendency seems to be in keeping with Eron's findings (4) in which he noted that there is an increase in "cynicism" and a decrease in "humanitarianism" among upper-classmen when first- and fourth-year medical students are compared. The experiences gained in this type of experimental program may stem a "negative" tendency developing in the third year, even increasing empathic communication slightly, whereas students in the conventional curriculum gravitate to a slightly less empathic position. In any event, much more remains to be investigated along this line.

The second hypothesis is borne out in that there is a correlation between time spent in medical school and perception of illness. Increasing experience, as might be expected, seems to reduce the apprehension or grimness with which the sickroom situation is viewed.

Adequacy, as evaluated by this method, is contingent upon the degree of independence of the student in solving medical problems. (This is probably an oversimplification.) The less "adequate" student sees himself as seeking authoritative support. It is interesting that at the outset there was no difference between students just entering medical school and those who had completed two preclinical years of basic science in medical school. However, after a year of rotation in the clinical departments, both of the third-year groups became significantly more adequate or independent than the freshman group.

The *Gestalt* or total pattern of affective areas started from the same baseline; except that by chance the experimental family care group was at a slight disadvantage. After participation in the family care program these students manifested a significant posi-

tive shift in over-all development of the affective areas measured. This trend differentiated the family care students from those in the first-year and in the conventional third-year curriculum as well.

It should be kept in mind that the sick-room situation test is still in a preliminary experimental version and requires further validation and refinement. Another consideration is that the sample is not only a small one, consisting of one group in each category, but is limited to this medical school and to a specific curriculum exposure. Although results cannot be generalized to other schools, preliminary evidence does indicate that affective aspects of the doctor-patient relationship can probably be influenced by involvement in a carefully structured setting. It is noteworthy that although the use of empathy was never mentioned as such by the staff, the most marked change in the experimental group occurred in the conative area of empathic communication.

There are also implications here for research in other professions, particularly those relying essentially upon an interpersonal approach. While technical competency can be reasonably assumed and assessed when a training program is completed, there is certainly a wide range in the quality of empathic communication among professionals in the behavioral

sciences. If curricula were formulated with a view to developing even greater skill in professional empathic communication it would be an invaluable aid, not only in dealing perceptively with clients, but also in providing more satisfaction for the worker. These areas include not only social work, where much emphasis already is placed upon professional interpersonal transactions, but also the behavioral sciences both inside and outside the health professions.

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1. This study is under the general direction of J. Garth Johnson, professor of community health and coordinator of the comprehensive family care program, Albany Medical College, Union University. The total evaluation study includes the analysis both of specially designed projective tests and of small group conferences. Financial support has been through a grant from the Kellogg Foundation.
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CORNELIUS BEUKENKAMP, JR., M.D.

# Anxiety activated by the idea of marriage as observed in group psychotherapy

In America, the median age level for first marriages has been lowering steadily. For example, in 1940 the figure for males was 24.3 years, compared to 1955 when the figure was 22.7 years. In the case of females, the 1940 figure was 21.5 years, compared to 20.2 years in 1955.<sup>1</sup> The sociological significance of this tendency has made intensive group psychotherapy a valuable if not critical psychological treatment.

Apparently the long engagement periods that were once characteristic of our American culture have disappeared. In fact, many young people find themselves having to adjust to and decide upon problems which have lifelong consequences frequently

in an interval of but a few weeks. As a result of this tendency for persons to marry at earlier ages, coupled with their strong natural gregarious drives, many of these individuals become particularly suited, and even eager, to face their various dilemmas through the framework of group psychotherapy. The goal of such therapy is not to interfere with the early rate of marriage, but rather to enable these young people to marry with deeper convictions, greater satisfactions and freedom from panic.

This placing together of males and females who are in their early twenties into groups of eight in which the stress is upon intensive interpersonal communications quickly and with candor reveals the psychological nature of their common problem—emotional loneliness. For example, upon entering a group and despite their social-

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Dr. Beukenkamp is a psychiatrist in private practice in New York City.

<sup>1</sup> U. S. Bureau of the Census, 1957.



mind ed ways, they soon evidence the fear of maintaining a close continuous emotional relationship. They begin to see that their getting together with others, though their contacts may have been often and numerous, have not been truly intimate and therefore have lacked deep emotional gratification.

The initial anxieties expressed about the working of the group often indicated that as individuals they did not feel secure or capable of handling themselves in situations requiring emotional negotiations. From this point in their treatment the feelings of personal unworthiness and the dread of self-exposure came to the surface when they discovered their fellow patients were similarly troubled. After this enlightenment they could then deal with their long-harbored fears and fantasies involving aggressive socially unacceptable attitudes. Such discussions brought forth a resolution—that their fears were based upon their lack of appreciation of the human equation. This was a result of not having been able to accept their normal animalistic cravings in a manner that they felt would be accepted culturally. In other words, these young adults had to outgrow the childish concept that sees life in terms of good and bad. And apparently through the mutual reinforcement that group psychotherapy affords, they could then accept the normality of these needs, free of guilt. These self-derived conclusions were supported by the group leader through emphasizing that human beings could live with their emotions without concealment and control if there was an integration of the emotions and the intellect. And, too, he would point out that all people at some time in their lives are torn between the wishes for sensual satisfaction and the demands of genteel behavior.

At this juncture of their treatment these young people were able to let down more

of their defenses. This was demonstrated by talking openly about whether or not they were actually in love and their doubts about their ability to love. Involved in these discussions was the conflict over the intolerance of their mates-to-be because of their shortcomings. The realization of the extent of this conflict had occurred when again experiencing this emotional dichotomy in the group. That is, their need for group harmony and function became jeopardized by their intense, critical, rejective hostilities toward particular individuals in the group.

This ambivalence produced another situation. Mainly, the threatened members, after becoming involved in several major head-on clashes with the group, began to feel secure enough to see that they had been struggling against a loss of personal identity. And they saw this as a parallel response to their impending marriages. Unknowingly, they had felt that marriage was an encroachment upon their identity. During this stage of their group growth this insecurity was expressed often by the individual participant as a fear that he would not be able to be "one of two," but rather that by some ill-defined process in his mind he might become only a part of an unhealthy "oneness."

With respect to the therapist's management, it was found to be more effective therapy not to place individuals who were romantically involved with one another in the same group. In practice, this proved to delay the emergence and resolution of the unhealthy "oneness."

The anxiety of losing personal identification was also expressed through the fear of infertility and of impotency. These qualms then led the focus of their discussions to the subject of heterosexual behavior. The females voiced their immature preoccupation with morality. In lieu of a sense of self-acceptance, they prepossessed themselves

with the subject of their worthiness as they related it to their need of virginity. On the other hand, the males in the group, in the same self-punitive attitude illustrating their lack of a greater perspective of human nature, spoke about their overconcern with sexual self-gratification.

Often in this orientation of self-flagellation, both sexes discussed masturbation. This stimulated a full conflagration. When the major portion of the embarrassment and self-deprecation subsided, they were then able to turn their interest to the more topical problems associated with marriage.

Among the uncertainties were their financial dependence upon their parents, since this too had a defeating influence upon their own healthy self-imagery. In some cases, where marriage meant leaving physically or mentally incapacitated relatives who were dependent upon them both emotionally and financially, feelings of self-worthiness were also attacked.

On the other hand, there was the manipulative use of marriage for raising one's self-status. Such people came to realize that their haste to wed was predicated upon a short-circuited approach to maturity. Upon exploration with these people who were in a hurry to get married, it was interesting to see how this erroneous attempt to obtain maturity was implanted by their parents and to some degree by society as a whole. With the realization that they were using marriage as a stepping stone to maturity, the neurotic need of approval from their parents and society, as well as from their prospective in-laws, abated. Until this realization, they had distorted the influence of their prospective in-laws to such an extent that they were unable to cope with these new relationships. This was true whether or not the prospective in-laws' behavior had been sound. As a matter of fact, it was found that many of these young

people felt selfish because they believed they were depriving their prospective in-law families of a love object. Thus, this too had an influence upon lowering the feelings of self-worthiness. And as a reaction-formation they expressed the fear of being "controlled" by their prospective in-laws. It was after the eruption of this identical attitude toward some of the group members that they were able to recognize this mechanism of defense and, more importantly, cease using it.

Another large area of interest troubling these young people was indicated by the males' confusion about their need for multiple sexual partners. At first, and with much rationalizing, the group discussions centered around their "freedom." But under scrutiny the rationalizing failed to hold back their apprehension and was finally expressed in the form of a question: "Why are we not able to live like others by being satisfied with one woman?" Following a short jesting period, which was an unconscious attempt to release the tension, the real issue would prevail. They questioned their masculine endowment and speculated about the causes underlying their deficiencies as males. There were whispers of trepidation that perhaps behind these multiple sexual pursuits there was a homosexual latency. In others, this inability to stay and be close to one sexual partner would arouse feelings that they were deficient in the depth feelings required for love.

In these discussions, where the males would dominate the interaction, again the subject of masturbation would arise. Here the greatest number of sexual misconceptions and distorted viewpoints would reveal themselves. The fear and threat of possible insanity was a common worry. Some would discuss their masturbation as a form of compromise; by masturbating instead of exposing themselves to the pursuit of multiple

sexual partners they saw themselves capable of maintaining their self-imagery and remaining within the interpersonal socially accepted pattern. In this way they felt they could engage in masturbation without the fear of punishment, while at the same time be relieved of their need to sexually pursue a series of women that might bring strong social censorship upon them.

Commonly, following this degree of progress in the battle of liberation from premarital panic, the next hurdle encountered was the idealism of mothers and its antithesis—prostitution. It was here that perhaps the basic conflict behind all these feelings of unworthiness, as they related to their confused sexual fantasies and behavior, became evident. The usual behavioral pattern revealed that the males had strong sensual satisfaction only with women whom they evaluated as unacceptable marital partners. It was with these women that they were most potent and free. Whereas, when they talked about the girls whom they respected or worshipped, inevitably the girls were the type who would meet the acceptable standards for women set up by their mothers. Underneath all the turmoil lay the cogent fact that they were convinced an ideal girl would reject them because of their lustful interests. Therefore, they had to suppress their lust in their relationships with these girls. And thus, with the proximity of marriage, they would be in serious conflict, since they had divided women into two kinds: nice girls like mother and sister, who were unapproachable, and loose women whom they thought of as prostitutes.

Because the groups were mixed with respect to the sexes, the males' distorted concept of the "nice girl" and the "sexually free girl" was more easily resolved.<sup>2</sup> For after listening to how these males were caught in the web of their dilemma, the females of the group were mobilized into

action. And since the males held these females in regard, their opinions carried a great deal of weight. They pointed out that sexual desire and the wish to express the sexual emotions freely were not the sole provinces of loose women but belonged to any healthy female. These "nice girls," who were about to be married, admitted openly that they too longed for sensual pleasures with the same intensity as the men, and further admitted that they had not remained virtuous. Through these disclosures the men were able to realize the faultiness of their previous concept.

With this reassurance the males would begin to see that their override idealization of mother had left them with strong feelings of emotional loneliness. They then could appreciate the pattern of their purposeless behavior. The need of approbation and love had formed the basis of their multiple sexual outlets but had not brought any understanding of love to them. They further realized that their choice of so-called "loose women" for their sexual gratification never really gratified these feelings of loneliness but merely kept them on a meaningless treadmill.

Quite frequently, once the males had exposed their sexual torment, the females in the group were encouraged to talk about a problem that had a close proximity—their excessive drive to have children. In a rather short time it became evident that this excessive need, with its preoccupation, had produced unknowingly a lack of comprehension and sensitivity to their potential husbands. It was as if they were so determined to have children that their recognition of the realities were being overlooked. This was true not only on a mundane level,

<sup>2</sup> Kotkov, Benjamin, "Unresolved Sexual Fantasies in Group Psychotherapy," *Psychoanalytic Review*, 44(July 1957), 313-22.



but equally in not taking into cognizance what the advent of a baby would do to their marriage. In other words, many of them revealed that they possessed the drive to have a baby almost as if this was the justification for being married, when actually it had been an unconscious drive to strengthen their own self-imagery. This drive expressed itself despite the fact that there was an emotional concern about their prospective husbands. But it would soon become evident that their concern for the prospective husbands' feelings had been placed secondary to their own ego-supporting interest through the need to demonstrate to themselves that they could have babies.

However, due to the influence of the group, it was not too long before they became more aware of their previous insensitivity and lack of relatedness to others. When this manifested itself through the challenge to cope with the various members in the group, they became more understanding of their previous self-limiting aims. Thus, the values in being able to relate to others without overinvesting in oneself or another human being at the expense of the whole group structure enabled the woman participant to have a more balanced perspective about her need to have a baby.

After working through the problems of multiple sexual outlets for the males and the females' excessive drive for maternalism, the groups were then ready to contend with the most volatile issue pertaining to their lack of self-worthiness. It dealt with those feelings of isolation which were driving both sexes into premature matrimony as a device for tranquilizing this basic anxiety. This critical phase was ushered in by the discussions of sexual gratification and child-bearing. For then these young people appreciated that they had, in a manner of speaking, overglamorized the idea of being

married. They had hoped to overcome the pain of the feelings of isolation through marriage without truly comprehending that marriage could not possibly serve as such a remedy. It is only fair to say that oftentimes this mistaken idea that marriage provides internal emotional stature had come not only from their own reasoning but even from their contemporaries' demands upon them to conform and be acceptable. When this phase was understood, a more healthy attitude as to what marriage was really like developed. They no longer had to depend upon matrimony to give them substance for their individuality. A confidence in themselves and their matrimonial undertakings then became evident.

With these gains, the last component involved in the dilemma of the premarital anxieties could be understood with clarity. This had to do with the sociological factors of education, culture and material backgrounds. These young people could then see that their regard for the existing differences in these areas was not the pivotal issue in whether or not their prospective marriages would succeed. Instead, through their group experience they could realize that these differences, although at times important, were not really the basis for the misunderstandings that creep into marriage. Rather, the ultimate result was the appreciation that the normally complex human being in a marital relationship with another normally complex human being creates a bilateral demand to relate with alacrity to this complexity without blaming its mishaps upon socio-economic factors.

In keeping with our short-term objective of reaching an emotional level compatible with a constructive entrance into marriage, the usual length of treatment was six months. The groups met twice a week for 90 minutes. It was the policy, even though many mundane difficulties were encount-

tered, to close the membership once a group had started. Only people with moderate neurotic personalities were accepted. Those with more severe problems were treated with other appropriate measures.

#### SUMMARY

Inasmuch as there is a constant lowering of the median age level for first marriages in America, there is an ever-increasing need to make a suitable psychological treatment available to those who must face the resulting problems. Intensive group psychotherapy serves perhaps as an ideal setting to cope with these conditions.

Thus, when young people nearing marriage were placed in mixed groups they appeared to be aided considerably through the realization that there was a commonality of their problems regardless of their cultural, educational and financial backgrounds. Most often these problems were outgrowths of a failure to comprehend their own lives beyond a childish morality. This immature and severely judgmental view of life had been employed as their defense against the instinctual drives. And upon realization that they were lacking emotional appreciation of their basic drives, they began to understand that their feelings of unworthiness and poor personal identification had been the basis of their numerous problems.

It was their group participation which showed them that actually they had been afraid to relate in close personal contact. This became apparent to them through the recognition of a reluctance to discuss their fears. In this recognition, the accompanying increased security had encouraged the open sharing of the especially endowed fantasy material. And with this successful growth, coming as it did within the multiple human structure of the group, there

developed a more resourceful personality for each of the individuals. There was a marked decrease of intolerance as well.

Through these interrelationships there came an end to a vicious parasitic cycle—excessive possessiveness that leads into helpless domination by others. In practice, it had proved that with the use of individual sessions the understanding of this cycle had been limited. It was only after experiencing this depleting bondage in the controlled atmosphere of the therapeutic group that the ability to resist and outgrow this form of behavior was attained.

Another gratifying development coming from the group experience was the rectification of the distorted views that were held responsible for inadequate marriages. These views had placed the causes solely upon matters such as money, educational levels, kinds of friends, relatives and social position in life. The inherent basic values of communal cooperation found in the therapy group made them realize that though such matters had their place in marriage the ability to work out an understanding with another person was the critical value involved. It was then appreciated that the person's dedication to meet and relate to the normal complexities found in all people had far more to do with the success of a marriage than any of the other factors.

In this new light of understanding, which comprehended the primary importance of human relatedness, the definitive problems took on a broader and different perspective. For example, the anxiety over infertility and impotency as well as the guilty feelings concerning masturbation and sexual experiences before marriage were understood as natural outgrowths of their incomplete psychological development. They then understood that, due to this immaturity, they had had to utilize defenses to checkmate themselves against such anxiety. However, they

further understood that these defenses had taken their toll by isolating them from their own feelings and by fostering their feelings of loneliness. The feelings of loneliness had driven many of them to attempt marriage as a panacea. But in their ultimate acceptance of all the individuals in the

group, in the realization that their problems were universal, these young adults had a return of the feelings of belonging.

And finally, with their self-imagery realistically reinforced, they found themselves able to enter marriage with the comfort and confidence they had desired.



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JOSEPH STUBBINS, Ph.D.

LEONARD SOLOMON, Ph.D.

# Patient government ...a case study

One of the most challenging tasks social psychiatry faces is that of providing the clinical practitioner with a workable theory of social behavior in the hospitalized schizophrenic patient. Such a theory should make sense of the many diverse forms of interaction found in schizophrenic groups. It is hoped that this case study in patient government will contribute to the development of theory. It brings together the impressions and observations culled from participating in the formation and operation of a patient government composed of long-term schizophrenic patients.

## SOCIAL BEHAVIOR IN THE SCHIZOPHRENIC

The major types of disturbance in social functioning that have received considerable attention in the literature have been the following: a desire for social withdrawal;

an inability to sustain appropriate affective relationships with others; an excessive dependence and passive compliant orientation adopted toward others; a severe deficiency in communicative role taking and empathic skills; and a deficiency in motivation to work.<sup>1</sup> Almost all of the subjects of this case study fit this generalized description. What kinds of rehabilitative functions can the technique of patient self-government perform for such chronic schizophrenic patients?

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Dr. Stubbins is now coordinator of the rehabilitation counseling program at Los Angeles State College. Dr. Solomon is a social psychologist at the Franklin D. Roosevelt VA Hospital in Montrose, N. Y.

<sup>1</sup>See *Behavior Pathology* by N. Cameron and A. Margaret. New York, Houghton, Mifflin Co., 1951, and also "Withdrawal as a Dimension in Schizophrenia," by G. King, *Journal of Clinical Psychology*, (October 1956).

## FUNCTIONS OF PATIENT GOVERNMENT

Patient government is regarded as a social instrument designed to reverse or minimize the effects of the regimentation of "total institutionalization"<sup>2</sup> upon the patient. Total institutions are characterized by the fact that they handle the human needs of their inmates by the method of bureaucratic organization of large blocks of people. Most large mental hospitals fit this description. The needs of organizational efficiency require that for most of his waking day the chronic schizophrenic patient be treated as part of an undifferentiated group, and that he be kept under almost constant surveillance. His verbalizations and feelings tend to be discounted because of their presumably pathological basis. His activity program and social contacts are regulated for him and sheer behavioral compliance becomes synonymous with health and adjustment. The long-term effects of such an atmosphere are that the patient expects the hospital or significant others to do the thinking and feeling for him.

The technique of patient government attempts to provide a milieu in which the patient is motivated, with group support, to express his ideas about problems in his ward or building, or in the hospital at large. A patient government group has certain characteristic relationships with hospital authority figures. The latter treat the patients' opinions and requests sympatheti-

cally and objectively. Hospital functionaries have a readiness to learn about patients' needs, to trade perspectives and to welcome patients' solutions to practical problems. With the sanction of hospital policy, personnel feel free to implement solutions in small cooperative groups set up to carry out decisions.

This case study begins with the formal structure of patient government as it actually developed, followed by a discussion of relationships to the social structure of the hospital.

## STRUCTURE OF PATIENT GOVERNMENT

The senior author stimulated the organization of the patient government and has participated as its adviser during the past year. The patients chose to name the organization the Welfare Council. The council consists of chronic schizophrenic patients on one of the buildings of the continued treatment service at the Franklin D. Roosevelt VA Hospital at Montrose, N. Y. It is organized with a chairman, three vice-chairmen, a secretary and several committees. Meetings are open and are held twice weekly. The weekly executive meetings are restricted.

Membership is voluntary and new applicants are readily admitted with a vote of approval from existing members. (No applicant has yet been refused.) Membership is confined to the patients of building 4, which has 150 patients; 50 are *bona fide* members of the Welfare Council. The median age of council members is 36 years, which is somewhat younger than non-council members. The median length of their current hospitalization here is approximately 3.5 years. Almost all of these patients had been hospitalized at some time previously. They were all classified as chronic schizophrenics.

<sup>2</sup> "Total institutionalization" is a term adopted by Goffman to denote those institutions—such as mental hospitals, prisons and army barracks—which control and regulate the major life activity of inmates and segregate them from outside involvement and intercourse. See "On the Characteristics of Total Institutions," by E. Goffman, *Proceedings of the Symposium on Preventive and Social Psychiatry*, Washington, Walter Reed Army Institute of Research, April 15-17, 1957.

### ROLE OF THE ADVISER

The adviser has been most active in training the president and the three vice-presidents in leadership techniques. In small group discussion, such topics as the following have been covered: conducting a meeting, achieving a proper balance between order and permissiveness, how to encourage wider participation, setting up committees, how to conduct an interview with a hospital authority, how to cope with hostile patients, etc.

Patients are encouraged to attend council meetings and to bring grievances and suggestions for the improvement of ward life to the group's attention. The adviser or his alternate is present at each meeting. The slightest indication of the withdrawal of support is immediately detected by the patients and they quickly relapse into apathy. Old habits of conformity and inhibition of constructive thinking constantly intrude upon the processes of patient government. These do not wither away with the introduction of free discussion. It is necessary to continually remind the patients that the discussion and criticism of current practices and routines of the hospital are not only allowed but that patient government was fostered by the hospital management for this very purpose. In the early months of council the hostile patients were of considerable help in demonstrating that the hospital could react constructively to criticism.

The adviser meets with individual patients to assist them in developing new projects and tasks for the council and its committees. This kind of grass roots work with the chronic schizophrenic is considered essential to the success of patient government; each individual patient leader needs support to feel certain that his ideas are not subversive of hospital authority, that his right to express his beliefs and feelings

are inviolable. Here and there it might be desirable to avoid the council's meeting with certain individuals who are out of sympathy with the idea of patient government until it is securely launched. Meetings between hospital authorities and council officers are arranged when requested by the adviser.

Chiefs of service and other functionaries are invited as guest speakers. In the ensuing discussion the patients get a clearer picture of the structure of the hospital, and as a result many regulations have come to have meaning and to seem less arbitrary.

In spite of the adviser's high level of activity in stimulating interest in new tasks for the council he tries to maintain a neutral position both at the general meetings and in the council's negotiations with hospital authorities. The adviser ought not place himself in the position of having to take responsibility for the recommendations of the council, nor of championing one group of patients against another. Only when the basic processes of the patient government itself are at stake does he clearly demonstrate where he stands. When the meeting threatens to become too disorderly he backs up the chairman; when the chairman rules that a given subject may not be discussed in the council he reminds the members they may discuss anything the group decides to; when a hospital worker attempts to misuse the Welfare Council he clarifies their relationship to hospital authority. The decisions of the council are largely recommendations to various hospital personnel.

### INTRA-GROUP PROCESS

In general, the members of the council consist of the more improved patients in the building. They see themselves as a select group and feel that their prestige would be diluted if they were to widen their



membership and thereby operate in close association with deteriorated patients. During the first six months of the life of the council the majority felt that the membership should be limited though the number admitted was gradually raised. There was a fear that the purposes of the council would be inundated by a large number of sick patients. Later experience showed these fears to be largely unfounded since few of the regressed patients are seen at the council meetings.

It is probable that the clinical practitioner who seeks to widen and intensify participation in patient government would be likely to face this problem. Possibly the improved patient senses the value orientation which views healthier patients interacting with deteriorated patients as negative or inappropriate. Patient government itself can modify these values.

Patients were unaccustomed to the required role of active participation. They came to meetings with a passive and imbibing orientation. It was easier to mobilize their interest than to galvanize them into action. This was not simply a function of the schizophrenic withdrawal. Rather there was a multiply reinforced assumption that taking action was contrary to their role as improved patients. *Action* for them seemed to mean *wrong action*. They automatically relied upon guidance from the adviser for the problem-solving modes to select. Their helplessness was evident when a proposal was made to change some procedure in the building. The patients would subject the proposal to the test of whether the hospital authorities would approve it. The screening process was partly reality testing (Would it be seen as practicable by the hospital?), partly ego testing (Does a healthy person make this kind of request?). Only after a proposal passes these tests are its merits considered by other criteria.

The persistence of this group dynamic is evidenced in the patients' repeatedly turning to the adviser for his opinion about a given proposal in spite of the fact that he has both implicitly and explicitly structured his role as an impartial agent. This imputing to the adviser of a role that he disavows both verbally and in practice flows from two quite different needs. The primary one is the need to have the adviser as an active ally and defender; the second is the paranoid need to see all processes of the hospital administration as selfishly motivated. Patients with paranoid attitudes still suspected that behind the adviser's neutrality lurked a commitment to the administration which had to be exposed.

The chairmanship of the meeting rotates among the president and three vice-presidents. This device enables more patients to have leadership experience and provides for an easy transition of leadership when a president is absent or leaves the hospital.

At this time, it seems difficult to point out any clear relationship between type of behavior pathology and leadership ability. However, it became clear that the patients required a forceful and active leader. Two of the council's most stimulating and effective leaders were classically hostile in character structure. This observation has tempted the authors to consider the hypothesis that hostility may be correlated with certain personality factors necessary for leadership in the context of long-term hospitalization. Those presidents who succeeded in motivating the patients into programs of activity did so by prodding individual patients and by seeking out contact with hospital authorities, thereby achieving concrete changes.

#### INTER-GROUP PROCESS

The majority of patients use the council as a means of achieving material improve-

ments in their way of life in the building. Some of the major changes that the council was instrumental in achieving were the setting up of a special recreation room, the changing of certain cafeteria arrangements, the establishment of a buddy system to aid regressed patients in eating and grooming, and the appointment of "contact men" to help the nursing assistants in certain chores.

Topics which elicit the highest interest and widest participation are grievances, requests for additional privileges and freedoms, and departmental functions and regulations as explained at council meetings by the hospital administrators.

Patients suggest a large number of ideas for innovations in the building. Most of these are never formally passed upon by the council, either because they are not effectively presented by their sponsor or because they seem lacking in merit. However, the main problem lies in the subtle social paralysis which develops when it comes to the implementation and reality testing necessary to crystallize such ideas into practice.

The council's officers have influenced various hospital personnel with whom they have come in contact. Particularly operating personnel, who normally have little direct contact with patients, have had to revise their image of the mental patient and reconcile it with the reasonable and cooperative attitudes the council officers have shown in their conferences with supervisory personnel. When the patient's requests cannot be granted the committeemen or officers have accurately and sympathetically reflected the administrative point of view in their reports to the patient group. Hence, there has been a reduction in hostility between patients and personnel, an emergence of an *esprit de corps* in the building, and an increase in patient-to-patient

and patient-to-personnel communication. There is a widespread understanding of the reason for many hospital regulations and policies which were formerly regarded as demeaning to the patient.

The active members of the council have been somewhat fearful and guilty that their desire for innovations might be considered subversive or pathological. There was the added fear of being ineffectual and exposing oneself to ridicule. With continued experiences of success in group action and the validation of individual suggestions, such fearful attitudes have declined. These emotional doubts were not without some basis in reality. There were occasions when a council request was interpreted as motivated by pathology or as indicative of poor judgment. Such interpretations outside the framework of individual or group psychotherapy is often a defensive maneuver, and can be a serious obstacle to the process of patient government.

It is considered crucial that a request of the patient government be negotiated on its individual merits, and in terms of hospital policy. An active patient government may threaten existent modes of functioning and well-oiled routines. The success of patient government depends heavily on the willingness of the hospital personnel to expose themselves to critical scrutiny and professional self-clarification. The absence of this kind of zeal in the milieu can be as great an obstacle to the success of patient government as the effects of mental illness and prolonged hospitalization. When patient government operates outside the mainstream of the hospital's functioning, it becomes a localized technique and as barren as a "gimmick" in its therapeutic effectiveness. Patient government may be no more than a window dressing designed to make the hospital look modern.

## EFFECTS OF PATIENT GOVERNMENT ON INDIVIDUAL PATIENTS

Patient government stakes its efficacy upon developing and expanding the residuals of affect and constructive interests within the patient. Starting with the simple concrete needs of long-term thoroughly institutionalized patients, patient government attempts to wedge into the finality and drone of the hospital's daily routines. Repeatedly the patients have learned through the granting of their requests that things need not always be as they *are*. The patients find that they themselves can affect their physical and social environment in ways which are beneficial to them.

Patient government gives added responsibility to patients, provides an arena in which the handling of responsibility can be evaluated for prognostic purposes, and permits the patients to behave in a more community-like setting. It gives substance to the notion of a therapeutic community. When operating at its best, patient government impels the patient to examine the obstacles to his better functioning as a human being. The attitude of love and acceptance, the freedom to state one's feeling and thoughts without fear of ridicule, and the invitation to active participation in recreating the life of the ward are all necessary ingredients for the process of resocialization as well as patient government.

Let us give a concrete example of this parallel: In the midst of a heated discussion, one of the sicker patients once made a long repetitive harangue; the others listened with embarrassment, irritation or patience but without interruption. When the chairman, expressing the sentiments of the council, gently chided him to express himself more directly and simply, the patient responded with appropriate affect by saying, "Thank you all for the charity of listening."

In any large "total institution," there is likely to develop such a rigidity in organizational structure that it becomes dysfunctional to the attainment of its avowed aims. In the case of the mental hospital, discrete special-interest groups operating independently to achieve narrow "therapeutic" goals may produce a resultant pattern which militates against patient rehabilitation. Constant evaluation of the organization's operating practices from several differing perspectives of experience is an excellent safeguard against the "freezing" of organizational practices that have become divorced from rehabilitation goals. This is one of the basic reasons why it is in the interests of hospital administration to nourish and encourage the formation and sphere of influence of patient government.

The experience with patient government during the past year has left the authors with the conviction that it is a significant technique for remotivating chronic schizophrenic patients. This paper as well as others in the literature suggest numerous hypotheses for controlled investigation into this aspect of social psychiatry. Through research the impressions and hunches surrounding this treatment technique may be wrought into a valid adjunct to the scientific management of patients.

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JOHN E. DAVIS, M.S.W.

ALEXANDER TOLOR, Ph.D.

# Aggressive behavior of staff members in a neuropsychiatric setting

The psychological literature abounds with detailed discussions of the psychodynamic significance that hostility may have for emotionally disturbed individuals and with the multitude of different ways in which patients may express this hostility in overt behavior. Relatively little attention has been paid, however, to the manner in which certain hostile feelings of professional staff members themselves may affect the subtle interplay between one staff member and another and between staff members and patients. Since the nature of these interpersonal relationships very probably helps determine in a significant way the over-all effectiveness of any therapeutic program, it seems essential to subject these interactions to the same careful examination that is customarily applied to the other elements of the therapeutic process. Moreover, for a fuller comprehension of the whole treat-

ment situation, an effort should be made to delineate some of the personality and situational variables which could, at least at times, account for changes in the intensity or manner of expression of hostility in the professional staff.

The purpose of this paper, therefore, is to report on some of the relevant personal experiences and observations of the authors which they encountered while working for several years in a large neuropsychiatric service of a highly respected military hospital.

It is recognized that in failing to utilize

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At the time this paper was written Lt. Davis was a psychiatric social worker and Dr. Tolor a clinical psychologist at the USAF Hospital at Parks Air Force Base in California. Lt. Davis has since left the Air Force and is now a clinical social worker at the Veterans Administration Hospital in Dallas. Dr. Tolor is now director of psychological laboratories at Fairfield State Hospital in Newtown, Conn.

experimental techniques and in relying exclusively, on subjective impressions, this study is beset by the usual limitations attending such an analysis. Despite the possibility of distortions in the interpretations of observed events which could result from personal biases of the observers, it is felt that a common sharing of even these limited and subjectively evaluated experiences might be of considerable help to other workers, specifically those of the three disciplines—psychiatry, psychology and social work—who are functioning in a similar type of setting. Although some of the generalizations might require modifications depending upon the specific hospital situation in which the professional worker finds himself, some of the insights gained might ultimately contribute to a more effective use of the skills of the professional worker and thereby lead to improved patient care.

Before embarking on a discussion of the specific types of hostile behavior patterns which have been noted in members of the staff, it might be appropriate to describe very briefly the hospital setting in which these observations were made. This particular neuropsychiatric service was the largest of any within the United States Air Force. It formed an integral part of one of the most respected and one of the largest Air Force hospitals in this country. Its function was to provide appropriate diagnosis and treatment to military personnel and their dependents who were referred by other installations located in various parts of the United States and overseas. There were facilities for closed and open ward patients, for all the psychosomatic therapies, including electric and insulin shock, and for outpatient clinic visits. Although the precise composition of the staff varied with time—not only with respect to who was assigned to any one position, but also with respect to the number of people assigned—there

were generally a minimum of 6 psychiatrists, 2 neurologists, 3 psychologists and 2 psychiatric social workers on the staff. In addition, the staff was supplemented by approximately 20 nurses, 40 psychiatric corporals, 3 enlisted technicians and certain ancillary personnel such as Red Cross workers, occupational therapists and physical therapists who were also available but not assigned directly to the neuropsychiatric service.

The assumption that all behavior is determined or multiply determined will be basic to the discussion of our observations; furthermore, we believe it is reasonable to assume that behavior at any particular time is dependent upon the interaction of conscious and unconscious, internal and external factors affecting the individual. Presumably, then, there is a cause-and-effect relationship between overt behavior and the underlying conflicts, needs, drives, attitudes and value systems which represent the individual's personality. Verbal expressions, including those having a hostile overtone, are considered to be equally subject to these explanatory principles and may originate from a variety of personal conflicts, needs, drives, attitudes and value systems.

When plans for this project were first formulated and subsequently developed it seemed that it would be possible to identify certain areas of conflict which could be directly related to various manifestations of aggressive behavior. The opportunity of identifying areas of special stress was thought to be excellent since all of the usual forces which are often thought to engender hostility were operating in our setting. For example, there were regular and non-regular, new and old officers, supervisors and subordinates, and different professional and subprofessional workers holding a variety of diverging views on the causes and treatment methods of mental disorders, ranging from

the most organic to the most functional, from the most dogmatically orthodox to the most radically unconventional.

However, as observations of staff behavior were made and as the information was recorded it soon became evident that the verbal expressions of hostility failed to fit neatly into any specific conflict categories. The causative factors which are often considered to be most related to the expression of hostility failed to account for a considerable part of the observed behavior. Consequently, at least for purposes of this paper, it seemed more advisable to describe hostile staff behavior as manifested in three very broad types of interpersonal relationships. The areas of observation which were finally selected were: inter- and intra-professional relationships, supervisory-subordinate relationships, and staff-patient relationships.

#### INTER- AND INTRA-PROFESSIONAL RELATIONSHIPS

Inasmuch as personal contacts among members of the same or different professions are much more accessible to observation than those between staff and patients or between supervisors and subordinates, we have available for reporting a greater number of interactions illustrating the expressions of hostility in the first area than in the others. Let us cite some specific examples of hostile behavior relevant to this area of interaction:

At a weekly professional staff meeting of the neuropsychiatric service an announcement was made concerning the required rating which would entitle nurses to membership in the officers' club. This rating, reflecting level of responsibility, was then translated into the salary equivalent and it was noted that most nurses fell within a relatively low range. One of the physicians thereupon inquired facetiously, "That is all nurses are worth, isn't it?"

The following verbal exchange occurred at lunch between a nurse and a physician. The male nurse expressed his need to return to the ward to attend to some patients whereupon the physician replied, "Why, I have yet to see a nurse do any work since I came here." The nurse then retaliated with anger, "If you physicians ever came out of your cubbyholes and quit hiding, you might know what was being done on the ward."

Another instance of aggressive behavior arose out of the fact that on several of the wards regular meetings were conducted of the ward personnel for the purpose of discussing common problems or new patients who had been admitted. At one of these meetings the ward physician presented a treatment plan which affected ward procedures and involved all of the personnel. This plan met with considerable resistance on the part of the members. For example, one nurse described this suggestion as "a lot of junk." The wardmaster added, "If you had to spend your time on the ward the way I do, you would do it differently." By virtue of the ward physician's decision-making function, the plan was eventually adopted despite the opposition. The doctor's closing remark to the rest of the staff made the point without equivocation that he considered the previous method completely antiquated and that it would have been more appropriate in the 19th century than at the present time.

It was also customary in our service to hold weekly staff meetings at which time a variety of information was disseminated and an opportunity was afforded for problems of importance to be presented by any member for general discussion and possible resolution. At one of these meetings the chief psychologist mentioned that referrals for psychological testing were frequently forwarded to the wrong section, and he out-



lined the acceptable referral procedure. One of the physicians thereupon immediately remarked, "Why make referrals at all since patients are usually discharged long before we get the report?"

In reference to psychologists and their tests, the following represent some typical hostile comments directed at them: "The thing I dislike about psychologists is the continual hedging which they do"; "They never tell us anything we don't know." In addition, on two separate occasions different physicians likened psychological reports to routine laboratory reports. It is noteworthy in this connection that during informal conversation and at the staff meetings the psychologists often reminded the physicians that psychological test findings could be of greater value to them if they were done following consultation between psychologists and psychiatrists on the specific purpose of the testing and on the kinds of information that were desired. Also they suggested that certain information could not possibly be arrived at by means of tests.

In the setting we are describing it had been one of the functions of the social work section to provide social histories on newly admitted patients. The staff physicians, psychologists and ward nurses on several occasions were noted to express themselves in the following manner: "It seems to me that the social histories are nothing but a fact sheet"; "All the social histories do is duplicate information already available." In some instances physicians have asked the social workers, "Why do you waste your time taking histories since they are never used?"

It had been the practice of social workers to conduct regular group therapy sessions for the patients on some of the wards. This situation often resulted in the social worker's being made the target for many expressions of hostility. One of the physicians,

for example, strolled through one of the wards shortly after the group meeting disbanded and inquired of the social worker why he conducted those group "seances" every morning.

Illustrative of hostile feelings directed toward the medical staff was the fact that many of the physicians were referred to as "pseudo-psychiatrists" or "90-day-wonder psychiatrists" by the social workers, psychologists and nurses. This comment was based on their short training period in psychiatry. It should be noted that some of the psychiatrists had received only 90 or 120 days of on-the-job training by the Air Force in the field of psychiatry and had been completely inexperienced in the psychiatric field prior to their entry into the service.

Furthermore, the psychiatrist's role was often defined by other staff members as that of an administrator who made dispositional decisions rather than that of a person who understood and treated emotionally disturbed patients. On some occasions the psychologists, psychiatrists and social workers were accused by the nurses of not being able to communicate satisfactorily with them and of not being able to comprehend the demands of the nursing service in establishing a smoothly functioning ward.

Many of the manifestations of hostile feelings as expressed verbally by staff members failed to follow the general pattern so far described under the discussion of inter- and intra-professional relationships. Much of the aggressive behavior noted seemed to bear no discernible relationship to membership in a particular professional group. Instead, the expressions of hostility often appeared to represent more basic personality reactions rather than specific role-oriented behavior. The following illustrations taken from both scheduled and fortuitously formed social contacts of the neuropsychiatric staff reflect hostile reactions apparently

unrelated to the particular group with which the professional worker identified.

For example, a staff member who was found sitting idly in his office was greeted by more than one of his fellow workers with the query, "When do you expect to start working?" and "Have you stopped seeing patients?" Similarly, a staff member who was seen away from his customary place of work was asked, "Where are you goofing off today?" and "Have you found a new hiding place?" Remarks like the preceding ones were a common occurrence and no staff member was immune from them.

At a recent meeting, one of the professional workers rationalized his declining additional responsibility by claiming to have insufficient time. This elicited responses such as, "If you worked from 7:30 A.M. to 4:30 P.M. you would have the time" and "What do you mean, no time? I haven't seen you do anything at all recently."

Several ward physicians who were assigned to the open wards occasionally held staff meetings at which problems occurring on their wards could be discussed. The granting of daily and weekend passes to patients was causing some discontent on one of the wards. This problem was mentioned by the ward physician. The response from another physician who came from the adjoining ward was, "I have never had this problem and if you spent more time on your ward maybe this would not be a problem for you either."

One of the staff psychiatrists who felt it was therapeutically important that patients be permitted to engage directly in decision-making on their respective wards and also be participants in some of the staff conferences presented this concept to some members of the staff. A veritable barrage of hostility greeted him in response to this suggestion. One comment that was made immediately was, "It has been done this

way (without having patients in attendance at conferences) a hundred years and you think it can be changed?" Other responses were "It will never work, and in addition I cannot see how any benefit would be derived from the change." One of the men declared, "It sounds fine in theory but let's be practical about this."

In any large institution powerful forces appear to be operating that discourage marked divergencies from the norm in working schedules and methods of performing the work. Those slight differences that existed in the neuropsychiatric setting described here often became the object of hostile remarks. For example, a newly arrived staff member demonstrated what was considered to be an unusual amount of zeal for working relatively long hours and also displayed much enthusiasm for initiating new time-consuming procedures. In a few days another physician expressed the feeling that he wished the new man would turn off his "super-charger." In addition, almost every staff member who found himself in a position of appearing occupied most of the time would be accused of "bucking for promotion" or would be informed that there is no relationship between amount of work performed and compensation received. The above-cited staff member was similarly informed by a co-worker that he would soon learn about the military. His naïveté allegedly stemming from his recent arrival in the military service was commented upon by others who implied that he would do things differently as he became more accustomed to the service routine.

In direct contrast to the situation described above stands another episode which occurred when a staff member arrived and soon demonstrated erratic work habits. He seemed indifferent to the usual routine of conferences, staff meetings and other requirements of a semi-mandatory nature.

This carefree, unconcerned appearance did not go unnoticed and in a short time certain comments were made. One co-worker inquired, "When do you expect to start working?" Another person sarcastically remarked that he certainly adjusted quickly to the military. He was also asked if he intended to make a career out of the service or expected to "go regular." It was also observed that at one of the staff meetings when this member's absence became conspicuous one of the physicians pointedly remarked about his absence to the chief of the service.

Some of the staff physicians were in analysis while working on the neuropsychiatric service. On more than one occasion when one of these physicians expressed his opinion in a staff conference or in an informal discussion, the co-worker who disapproved of a particular point of view asked whether he had any difficulty with his analyst that day. Moreover, at times it would be suggested by one of the staff members that the individual in analysis had better "work that through" with his analyst.

To conclude the section pertaining to inter- and intra-professional expressions of hostility, it might be added that one particular expression was used quite frequently and indiscriminately by many of the staff members—they referred to a co-worker as being "sick." Ascribing to another professional worker poor mental health whenever one disagreed with his point of view or disapproved of his behavior seemed to epitomize the intense hostility felt on occasion. The word *sick* seemed to be the one descriptive term which carried with it the greatest justification for the rejection of that individual.

#### SUPERVISORY-SUBORDINATE RELATIONSHIPS

Indigenous to any complex organization or institution such as a military hospital is a

hierarchy of responsibility and authority necessitated by the desire and need of all concerned for a smoothly functioning operation. An organizational or administrative structure like the one described in this paper seems to facilitate the occurrence of interpersonal conflicts between those individuals who have a greater and those having a lesser amount of authority and responsibility. In the neuropsychiatric service we are describing, ample opportunity was afforded for observation of hostile interplay between supervisors and subordinates.

For example, a psychiatrist who held a supervisory position and who felt his authority was being encroached upon by a secretary on one occasion during staff conference turned upon this secretary and asked, "How many hats are you wearing anyway?" This same supervising psychiatrist, who initiated some different procedures after his arrival, became the recipient of a veritable barrage of hostility from some of the subordinate staff psychiatrists, who referred to him as "The Great White Father." This was only one of many derogatory names attached to this supervisor by his subordinates. Apparently the labeling or nicknaming of individuals presented a convenient and common device for expressing hostile feelings toward supervisors and subordinates. To cite another example, a rather aggressive and manipulating airman who occupied a position within the clinic structure where he exerted a greater degree of control over scheduling appointments than is ordinarily the case was often the object of considerable hostility. Even though he was an enlisted man, he would frequently be addressed as "Colonel" by the physicians and other professional staff.

It was a well-known fact that many of the professional people on the staff had a professional title by which they preferred to be addressed rather than by their military



rank. It seemed as though one of the favorite ways for a subordinate to express hostility toward a supervisor or higher ranking member of the staff was to refer to him or address him by his rank rather than his professional title. For example, one of the staff members always referred to the chief of the service by his military rank rather than by the title *Doctor* whenever he objected to one of his proposals.

Perhaps one of the most interesting examples of expressed hostility took place at a weekly conference devoted to discussing therapeutic techniques. This meeting was conducted by one of the supervising psychiatrists. The psychiatrist in charge preferred a particular chair located in a particular part of his office. There were many instances in which some of the subordinate staff physicians would contrive to rearrange the chairs prior to the supervisor's arrival, seat themselves in the preferred chair, or make certain that all of the chairs were occupied, thereby attempting to precipitate an embarrassing situation for their "supervisor."

There are several further illustrations reflecting a considerable amount of hostility in the relationships between supervisors and subordinates. For example, an enlisted man who reported to the neuropsychiatric clinic was assigned by the clinic supervisor to fairly menial duties which were not commensurate with his rank and experience. This was a departure from the previous policy of assigning the less desirable duties to the lower ranking and less experienced technicians. To illustrate again the role which hostility may play in the assignment of duties, a staff physician was assigned to one of the psychiatric wards and given certain prescribed duties; he inherited the same title and responsibilities as his predecessor but subsequently found that the deci-

sion making power of the assignment had been assumed by his supervisor.

To offer another example of hostility, let us again use the staff meeting as the setting. Some of the staff members at the weekly staff conferences presented problems or posed purely academic questions which could not be solved immediately or over which their supervisors could have no control. In these instances the purpose was often to embarrass the supervisors in front of other staff members.

Although on an over-all basis approximately as many hostile expressions were observed in supervisor-subordinate relationships as in other interactions, the former tended to be more covert, indirect and guarded than the latter. Since the critical remarks of supervisors and subordinates were restricted, in the main, to the privacy of their respective in-groups, it was more difficult to document these expressions than the hostile expressions occurring during other interactions.

#### STAFF-PATIENT RELATIONSHIPS

The interaction of patient and therapist has been the subject of much scrutiny and study, as have some of the multiple environmental factors which promote or interfere with therapeutic change. The literature abounds with discussions concerning the effect that the attitudes and feelings of the staff have on patient care. We are attempting in this section of the paper to illustrate only staff expressions of hostility toward patients. Because of the confidential nature of individual interviews with patients and the prevailing philosophy that people who are caring for mental patients should be accepting, objective and emotionally controlled in their relationships with patients, the feelings of hostility expressed toward patients are apt to be less overt than those toward co-workers.

It is expected that a certain proportion of patients will be referred to any medical center who actually do not require hospitalization. In spite of this realistic problem, admitting physicians often seemed to utilize this fact as a means for ventilating their hostile feelings towards patients whether they required hospitalization or not. For example, quite frequently the staff physician who was responsible for screening all new patients would be heard to remark indiscriminately, "Why did they send him here?" This type of reaction was noted not only on the admission service but also in the outpatient section as well as on the open ward sections to which patients were subsequently transferred. Frequently the ward physician would react to his frustration resulting from his inability to cope with a therapeutic problem by being overly eager to rid himself of the responsibility of caring for a patient. Thus, for example, a physician might remark gleefully, "I don't want him, you can have him, he's too sick for me!" upon transferring a patient to another ward. Some physicians were equally eager to discharge patients from the hospital as expeditiously as possible for the same reason.

Some of the professional and subprofessional staff adhered to the philosophy that patients should not be coddled but should be disciplined rigidly in accordance with military practices. It was not uncommon to hear a ward nurse or wardmaster ask a patient, "Do you think this is a hotel?" or comment, "This patient acts as if he were visiting a country club." Occasionally patients were asked by their physicians, ward nurses or corpsmen whether they were enjoying their "vacation." Even at one of the ward staff meetings it was noted that in discussing the ward and the patients one staff member repeatedly commented that the patients "sure have it 'made' here, don't they?"

One of the wardmasters whose duty it was to select patients for a variety of chores around the hospital sometimes described the patients as a "bunch of crybabies." He also would attempt to obtain from the professional staff support for his contention that they behaved like immature children.

An outstanding illustration of staff hostility toward patients was the frequent tendency of the professional person to discount the potentialities for mental health of his patients. As a consequence, not only were patients often described as being more severely disturbed than they actually were but also they were often considered to be inherently incapable of making an adequate adjustment. The frequent description of patients as representing "piss poor prognosis" seems to reflect an attempt at justification by the professional person for his failure to make significant therapeutic progress with his patients.

## SUMMARY AND CONCLUSIONS

The above-cited illustrations of aggressive behavior by staff members represent only a relatively small proportion of all such activity that was observed. Our intention was not to present a fully documented account of all aggressive behavior during a specified period of time but to offer a sufficient number of selected examples to enable the reader to get the flavor of this type of interpersonal interaction.

The most significant conclusion to be drawn from our observations is that hostility as a factor in staff relationships is an identifiable variable and capable of being subjected to investigation. Furthermore, it seems that hostile expressions of staff members are much more prevalent than is generally recognized. We have demonstrated in this study that these feelings may be revealed by means of a variety of verbal expressions, many of which are couched in

pseudo-facetious terms, and that they occur in a number of different situational settings, most of which would betray nothing of a hostile connotation to the casual observer.

The precise role that this type of aggressive behavior plays in terms of therapeutic results remains obscure. However, it would seem that a lack of awareness by the professional worker of when and how he is resorting to hostile behavior in his interpersonal relationships is especially detrimental to the welfare of the mental patients with whom he comes into contact. It is not our contention that all hostile staff expressions necessarily result in destructive consequences for a therapeutic program. We do believe, however, that if the irrational basis for hostile feelings and associated behavior patterns remain repressed, hostility will tend to be poorly controlled, and an obstacle toward the basic acceptance of other staff members and/or of patients may be the result. The validity of this hypothesis awaits further study.

A number of other hypotheses suggested themselves as we focused our attention on the manner in which professional personnel express their hostile feelings. One of these is that hostility will tend to be expressed more readily in those situations in which the professional worker feels less secure. Insecurity may stem from internal conflicts and problems related to early childhood experiences or from stressful situations even in the absence of any basic conflict. If the insecurity is based on neurotic, unrealistic motives, the resulting hostility is likely to be less amenable to change than is insecurity based on situationally determined, more realistic factors. For example, it would seem far simpler to alter the intensity or direction of hostility of a psychiatrist who feels frustrated because of his inadequate training

for a particular assignment than to change the hostile patterns of a basically maladjusted individual.

Another hypothesis which might be advanced is that hostility will tend to be more readily expressed in those situations in which the social subgroup with which the individual identifies himself reinforces and encourages this type of behavior.<sup>2</sup> This hypothesis would explain the frequency of interprofessional conflicts, and, because there are multiple identifications at one and the same time and on different occasions, intra-professional conflicts as well.

A third hypothesis derived from our observations states that hostility will tend to be expressed more directly in those situations in which the apparent object of the hostility is perceived as being relatively weak, ineffective in retaliating or isolated from social support by others. The obverse hypothesis states that hostility will be expressed more indirectly in those situations in which the apparent object of the hostility is perceived as being relatively strong, effective in retaliating or allied with others whose support he can rely upon. Thus, for example, hostility will tend to be more frequently and openly directed at a psychiatric consultant whose theoretical orientation differs from that of the chief of the service than at a consultant whose theories are frankly supported by the chief of the service.

An important hypothesis having significant implications for the introduction of ameliorative measures is that hostility will tend to be expressed more readily in those situations in which the individual lacks awareness of his motives. In case a person freely relies upon the mechanisms of repression, displacement and rationalization, he would also be disinclined to accept the desirability of change in his hostile behavior.



Obviously all of these hypotheses require further study and evaluation before they can be accepted or rejected. The very fact that so many promising areas of research have developed from this project attests that this is a fruitful approach to the problem of staff hostility. It is hoped that other research workers who share an interest in these long-neglected problems will find our observations useful and, hopefully, will follow

through with some of the hypotheses which have been tentatively advanced.

In conclusion, we would like to emphasize that contrary to the impression one might get from reading only these selected illustrations of hostile staff interactions, the over-all atmosphere prevailing in this hospital was generally a positive one, conducive to emotionally rewarding experiences for both the staff and the patients.

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WILLIAM L. PELTZ, M.D.

WILLIAM R. CRAWFORD, M.D.

# Assistants in the private practice of psychiatry

This report describes several types of assistantships in the private practice of psychiatry, a subject on which no previous reports have appeared in the literature. Moreover, it includes reactions to such arrangements obtained by means of questionnaires from 100 psychiatrists throughout the country.

The authors believe that the paper contains information which will be of interest to busy psychiatrists who would like to extend the scope and effectiveness of their clinical work. They also believe that it will be of interest to young men who are embarking upon their psychiatric careers and want further experience after their residencies or who need the financial security of a part-time or full-time job. It is believed that a senior man can extend his own efforts further in the direction of mental hygiene by having assistants in his prac-

tice and that he can offer his assistants knowledge and experience along these lines which they had not received during their residency training program.

During recent years, at the Institute of the Pennsylvania Hospital in Philadelphia several members of the staff, including the late Dr. Edward Strecker and Drs. Kenneth Appel, Joseph Hughes, Manuel Pearson and the senior author, have had one or more assistants working for them.

The arrangements of these men vary somewhat. In some situations it may be customary for new patients to be worked up by the assistant before they are seen by the senior man, whereas in other situations the senior man sees the patient first. Some

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Dr. Peltz is an associate professor of psychiatry and Dr. Crawford an instructor in psychiatry at the University of Pennsylvania School of Medicine.

arrangements are on a full-time basis which do not permit the junior man to see private patients of his own; others are on a part-time basis with a definite number of hours of the assistant's time being designated for the senior man; and still others are flexible in this respect in that the assistant is on his own except when he is seeing patients whom the senior man asks him to treat for him. Some senior men meet almost daily with their assistants to discuss the patients; others meet once a week or less frequently. In some plans a certain percentage is paid to the junior man, depending upon his experience or ability; in others a flat salary is paid; and in still others there is a basic salary with a bonus which is decided upon by the senior man.

The senior author, a psychoanalyst by training, is engaged in half-time practice of psychiatry and half-time teaching at a medical school. His efforts in the direction of mental hygiene in preventive psychiatry lie in connection with his teaching psychiatry to future medical practitioners and with his serving as consultant to the Marriage Council of Philadelphia and the Lawrenceville and Hill Schools, these being fairly large boys' boarding schools not far from Philadelphia. The primary reason for his taking on a half-time assistant five years ago was that when his schedule was crowded he was frequently called upon to see students at these schools. He was generally able to carry out consultations but often could not take the students on in therapy because his schedule was filled. The schools and he both felt that as consultant he could be of greater help to the school if he had an assistant treat some of the students. He could thereby remain in closer contact with the therapy situation than if he referred the students to colleagues. Moreover, he could see the students' parents or talk things over with the school authorities without his do-

ing so interfering with therapy to the same extent as it might if he himself were treating the students.

In this particular arrangement the assistants usually work for the senior man for two or three years. They have ordinarily begun on a half-time basis (20 hours a week), the rest of their time being devoted to their own practices. While seeing the senior man's patients in his offices, they are building up their own practices elsewhere. During the second year they usually work about 12 instead of 20 hours a week for the senior man, and the third year about 4 hours. During the third year the senior man has taken on a second part-time assistant.

In addition to being available at any time for emergency conferences, the senior man spends an hour every week going over cases with the assistant during the first year they work together. During the second and third years, such reviews are held less frequently.

Letters to referring physicians about patients being seen by the assistant are usually drafted by the assistant, gone over by the senior man and sent out over the senior man's signature.

Billing of patients is done by the senior man, listing the dates of visits made by the senior man separately from those made by the assistant. A statement appears on the bill to the effect that the bills are payable to the senior man.

During the first year the assistant receives 60% of the gross income from patients seen for the senior man during the 20 hours per week assigned for the senior man's use. (The amount of \$4,000 is guaranteed.) During the second year the assistant receives 70% of the fees instead of 60% and during the third year he receives 75% of the fees from patients whom he has seen for the senior man.



When the assistantship ends, in the authors' arrangement (in contrast to some arrangements in which the senior man retains all of the patients for himself), the assistant and senior review together all the assistant's cases and decide what the disposition of the latter's patients should be in terms of the needs of each patient. The matter is then discussed with the patients. Some patients terminate therapy, others transfer to the senior man or to another assistant, and still others continue with the original assistant in the latter's practice.

A matter of simple arithmetic will reveal that with fees averaging around \$15 an hour and with an assistant working 20 hours a week for 48 weeks, the assistant would receive \$8,640 and the senior man \$5,760. Actually, because of empty hours, cancellations, etc., the gross amounts are less than these figures. Extra secretarial time, office supplies and time devoted to supervision during which the senior man would otherwise be seeing patients means that the senior man has netted about \$3,000 during an assistant's first year and usually about the same during the second year.

To find out what other psychiatrists think about arrangements involving assistants in the private practice of psychiatry, a questionnaire was prepared and distributed to over a hundred colleagues in various parts of the country. The first 100 replies were analyzed, all but 5 of them from psychiatrists who have been in private practice. A total of 68 have had or are receiving psychoanalytic training. Of the 100, 49 have had experience in practice either as assistants or with assistants and 18 of the 49 have had assistants working for them. The remaining 51 have neither worked as assistants nor had assistants.

Several observations based on a statistical analysis of the responses, seem worth reporting.

Although there were felt to be both advantages and disadvantages to patients, to senior men and to assistants there was more expression of favorable than unfavorable reaction toward assistantships in this group of 100 psychiatrists. Respondents who had experience as or with assistants had a somewhat higher opinion about the advantages of assistantships than did respondents without such experience, and so did respondents without psychoanalytic training as compared with respondents with analytic training.

Whether or not they had ever worked as assistants or had had assistants, respondents to the questionnaire were asked to list what they considered to be the advantages and disadvantages of such plans for patients, senior men and assistants. There follows a summary of the responses.

#### ADVANTAGES TO PATIENTS

Some respondents felt that patients might frequently be able to get appointments more readily with assistants than with senior men. Moreover, they might frequently derive more benefit from therapy by an assistant with supervision by a senior man than from being referred outright to a younger man just starting in practice and working alone. They would have the benefit of having the senior man and the assistant confer with each other and hence of two trained minds and combined opinions instead of just one. Sometimes they would receive better coverage from assistants than from senior men who are likely to be extremely busy with practice and administrative work. If the therapist should be ill or unavailable for other reasons, a patient could be certain of coverage by someone who is familiar with his case. A patient who cannot afford the senior man's private fee might sometimes be treated under his supervision by his assistant at a lower fee.

It was suggested too that sometimes there are advantages to patients to having collaborative, joint or multiple therapists.<sup>1</sup> For example, there may be advantages to having one marriage partner treated by one therapist and the other partner treated by a therapist who is associated with or works closely with the first therapist. The same advantages frequently obtain when one therapist treats a child or adolescent and another therapist treats the parents. Such a collaborative form of therapy can frequently be achieved more readily between a senior man and his assistant than between two colleagues who wish to collaborate but are accustomed to working completely independently. Sometimes one may assume the role of therapist and the other of administrator.

Patients with particular needs sometimes profit by being assigned to an assistant who has different attributes or capacities than those of the senior man. For instance, a female therapist may be indicated for a particular patient.

#### DISADVANTAGES TO PATIENTS

It was suggested that some patients may feel they are being treated by an "inferior" or "second-rate" therapist when they are referred to an assistant. They may feel they are receiving inadequate treatment under the guise of better treatment. Such patients may feel they are paying for the services of a senior man and are receiving the attention of a junior man. Moreover, patients may resent the fact that part of the fee they are paying goes to a psychiatrist who they feel

has not earned it. It was suggested too that acceptance or selection of patients for treatment may suffer in that the senior man may accept some patients realizing that not he but the assistant will be treating them.

There may be "splitting" or dilution of the transference or treatment relationship and complications in identification and in the development and resolution of transference when some patients are treated by assistants, whether or not they are seen by the senior man (well-established conferences between senior man and assistant may help resolve these difficulties). Other difficulties in transference may occur if the senior man shifts patients from one assistant to another.

Sometimes there may be lack of adequate communication between the senior man and his assistant, with resulting confusion of roles and division of responsibility. The senior man and the assistant may each "pass the buck" to the other with the result that neither may actually come to grips with problems. When assistants leave, patients may experience separation anxiety or may be confused as to whether to continue with the assistant, who will now be on his own, to remain with the senior man or to be transferred to another assistant.

#### ADVANTAGES TO SENIOR MEN

Senior man will have an increased and more steady source of income. By calling on their assistants, they will be able to handle emergencies more effectively, will have greater freedom from unpleasant calls and pressures of practice, and will have more adequate coverage for patients during vacations, illnesses and other absences from practice. They will be more able to take on professional responsibilities outside of practice such as teaching, committee work, etc. Moreover, they will be less lonely in their work. They will derive intellectual and professional stimulus as a result of

<sup>1</sup> See Leo Alexander and Merrill Moore, "Multiple Therapy in Private Psychiatric Practice," *American Journal of Psychiatry*, 113 (1957) 815-23; Don D. Jackson, "The Psychiatrist in a Medical Clinic," *Bulletin of the American Association of Medical Clinics*, 6(1957) 94-100.

preceptoring and from exchanging ideas with young men who have recently received their training. In addition, they may derive some feeling of satisfaction from having assistants.

Finally, having assistants enables senior men to retain the good will of physicians who refer cases to them, when otherwise pressure of work would require them to refuse such cases.

#### DISADVANTAGES TO SENIOR MEN

It was suggested that the assistants may take too much or too little responsibility, or they may fail to keep the senior men informed about their cases. An incompetent assistant could hurt a senior man's reputation and practice.

One respondent felt that a senior man might feel threatened by his assistant if he himself had gotten behind in current ideas and methods. Others felt that an assistantship arrangement might be too time-consuming if adequate supervision was to be given.

Occasionally it is difficult for senior men to relinquish their assistants as they become more experienced and want to be on their own, and sometimes they find it difficult to let patients go with their assistants when the latter embark on their own practices. It was suggested too that assistants might at times act out in relation to senior men the various transference problems to authority figures which they experience in their training analyses.

#### ADVANTAGES TO ASSISTANTS

Assistantship arrangements offer an opportunity for assistants to learn about psychiatry and about the business and professional aspects of private practice from experienced senior men. They can gain practical experience without having to carry the full re-

sponsibility while still in what amounts to a state of apprenticeship. There are many things about private practice which are not and cannot be taught in residency programs, partly because of some essential differences between the two—for instance, the continued, uninterrupted care, often over a period of many years; greater experience in out-patient work than some residency training centers offer; the opportunity when working in private practice to follow one's patients through a period of hospitalization and thereafter in office practice; the degree of *personal* responsibility for the patient's welfare in practice as opposed to the emotional support that a resident gets from the institution in which he is training; and the extra facilities that private patients can sometimes afford, such as private rooms, outside arrangements with companions, special services, vacations, special diets, etc.

Assistantships offer financial security after residency while assistants are obtaining analytic training or are getting started in practice on the side. Some men who have finished their residency training plan ultimately to move elsewhere to practice but are only part of the way through their analytic training. Therefore, they have no desire to open a practice of their own for two or three years in this particular community and then have to move. Rather, they are interested in a salaried position, such as an assistantship, which will guarantee them adequate security for these two or three years and which will broaden their professional experience at the same time.

Assistants may not only identify to some extent with senior men but may derive confidence and ego-support from working with them. Moreover, they gain a certain amount of prestige because of the reputation of the senior men. They acquire discipline in having to formulate problems for the senior men. They may ultimately re-



ceive referrals in their own practices from patients or from physicians whom they come to know as a result of working with the senior men; and the senior men may recommend them for various positions during the ensuing years as a result of their having worked together.

#### DISADVANTAGES TO ASSISTANTS

It was suggested that there may be limitations to the assistant's freedom, and that assistantships constitute a sort of "second-class citizenship." Sometimes there may be absence of sound teaching or adequate supervision or there may be lack of communication of information about patients by senior man to assistant. Sometimes too the senior man may delegate too much or too little responsibility to the assistant. If the senior man is too controlling, the assistant may not develop a desirable degree of initiative and independent judgment, and he may tend to become a permanent "second man."

Occasionally assistants experience feelings of resentment against the senior man, possibly because they do not feel they receive as much income from patients as they deserve or in other instances because of transference feelings.

One respondent felt that an assistant might have to treat patients whom he himself would refuse to treat or might have to treat patients in a way in which he would not treat them under other circumstances.

It was suggested too that having been an assistant might cause people during later years to think of the younger man as still being associated with the senior man as his assistant when actually he is now on his own. Therefore, some patients might not be referred to him who actually would be, if other people knew he was conducting his own practice.

#### COMMENTS AND CONCLUSIONS

It is the authors' belief that whether assistantships are helpful and satisfactory for patients, for senior men and for assistants depends in large measure upon the points of view and attitudes of the senior man and his assistants. If the welfare of all concerned and particularly that of the patient is kept constantly in mind, such arrangements will work; if not, they will fail to some degree in one respect or another. There must be a flexibility and an ability to see the other person's point of view. For example, the senior man must recognize the needs of his assistant—whether the latter be needs for dependence and supervision or for an increasing degree of independence and responsibility. The authors realize that there can be pitfalls to such arrangements but believe that if the senior man and the assistant are aware of them, if they discuss them openly and together decide how to avoid them, the best interests of everyone can be served.

The similarity to the father-son relationship, the mother-son relationship (transference of dependency, for example) and sibling relationship may create problems in the relationship of senior man to assistant. The success or failure of the lines of communication and cooperative approach to patients and the over-all state of "health" of the practice may ultimately rest on the cathexis which the senior man has, not only in his patients, but in his assistant and also on the cathexis which the assistant develops in the senior man's practice. The absence of such cathexis tends to lead to unnecessary sibling rivalry between assistants, and to hostility between assistant and senior man, with consequent acting out of power struggles in various ways. When on the other hand the senior man, as the "good parent," cathects the assistant as well as his practice, he automatically helps the assistant

ant with the management of cases and with professional growth and development.

It has been suggested that the word "associate" should be used instead of "assistant" inasmuch as it presents the junior man as more of a colleague, increases his sense of importance and self-assurance and leads to a greater feeling of confidence in him on the part of the patient. (In this paper the word "assistant" has been used intentionally for the sake of clarity.)

It is believed that a plan which permits the assistant to have increasing amounts of time for his own practice each year will lead to fewer difficulties and will foster his ultimate emancipation.

It is important that the arrangement be free from any implication of fee splitting. Among other things, this means that patients should know that they are being treated by an assistant on the senior man's service and that the billing will be done by the senior man.

In conclusion, it is hoped that this report will be helpful to those who are involved or who may become involved in such arrangements, either as senior men or as assistants.

## SUMMARY

Based on the personal experience of the authors and on information derived from questionnaires which were received from 100 psychiatrists throughout the country, a report is presented on the advantages and disadvantages of arrangements involving the use of assistants in the private practice of psychiatry. The reactions of the respondents indicated considerable divergence of opinions. On the whole, however, there was greater expression of favorable than of unfavorable opinion.

Detailed advantages and disadvantages to patients, to senior man and to assistants are cited. The authors' arrangement is described, not with the idea of its being the ideal plan for other people in other situations but to illustrate the details of at least one type of arrangement. Other arrangements are mentioned briefly.

The authors believe that when an assistantship is carefully conceived and when it is put into operation with proper attention to such matters as supervision and the dynamics of a complicated professional interpersonal relationship, the advantages to patients, senior men and assistants outweigh the disadvantages which may still exist.

# Characteristics of a psychotherapeutically oriented group for beginning teachers

The purpose of this paper is to present a report of the findings of a 1-year pilot project conducted at Brooklyn College for newly-appointed elementary school teachers who had received their undergraduate teacher training at the college and who were at the time of the project engaged in graduate study in the teacher education program. The project was conducted by the writer, a clinical psychologist, in the setting of the Educational Clinic, which is an adjunct to the teacher education program.

The project was established with several purposes in mind. The primary aim was to afford a group of beginning teachers an opportunity to meet with a clinician to discuss such problems of adjustment as they might experience in the school situation. It

was expected that these would include problems with relationship to colleagues, children and supervisors. It was anticipated that the clinician would attempt to help the teachers formulate and clarify such problems with respect to their own role as teachers, and thus help establish a more objective basis for classroom behavior. The project was also viewed as a means of providing the teacher training institution with a greater insight into the needs of the prospective teacher with a view toward more effective accommodation of these needs.

The recent literature is sparse in reports of similar types of studies. Berman (1, 2) worked with a mixed group of educators in the Boston area over a 15-week period in an attempt to improve the functioning level of the individual through increasing his understanding of himself, his students and

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Dr. Nass is a psychologist in the educational clinic of Brooklyn College.



his colleagues. The approach was a combination of group psychotherapy and educational techniques, and the group contained people of varying ages and backgrounds. The data were considered both in a teaching context as well as in a psychotherapeutic vein.

Buckley (3) met with 8 teachers of varied age, experience and background in a group psychotherapy situation. He reports positive results in terms of certain objective criteria and indicates the beneficial nature of the program to the people involved. During the course of his program, contact was maintained with the schools and supervisors of the group participants and the reactions of the supervisors to changes in the job performance of the group were obtained.

Further descriptive reports of similar types of studies are not available. However, several investigations regarding interpersonal problems faced by teachers have been reported. Thus, Jersild (5) in a survey of over 1,000 teachers and graduate students found that an overwhelming proportion of them felt the need of self-understanding in order to facilitate growth, and advocated some kind of group experience in an educational setting. "The teacher's understanding and acceptance of himself is the most important requirement in any effort he makes to help students to know themselves and to gain healthy attitudes of self-acceptance."<sup>1</sup> Glidewell (4) in a role-playing situation, found that teachers' effectiveness as leaders increased when group members were able to express and accept their feelings. The major concerns of a group of 120 student-teachers was investigated by Travers and others (7), who found that the two primary concerns of the group were discipline and the desire to be liked and accepted by their students.

## PROCEDURE

A letter describing the purposes of the project was sent to 100 early childhood and elementary education graduates who had completed their undergraduate degrees within the preceding year, who were enrolled in the 5th-year teacher education program, and who were currently teaching in the New York City public schools. Ten affirmative replies were received requesting further information and interview arrangements. During the process of screening, two individuals dropped from the project prior to the interview. The remaining eight were interviewed individually to evaluate such factors as awareness and acceptance of individual problems, ability to express feelings, and motivation for applying for the group. The nature of the project was described to each applicant and the confidentiality of material was stressed. As a result of the interviews it was decided to exclude two individuals because of their failure to meet the criteria for admission. The remaining six, all of them women, proved to be interested persons who were well motivated toward clarification of their school problems. Two of the six were kindergarten teachers; the remainder taught at the elementary level.

The group met over the period of one year for 32 sessions of one and a half hours each. While the project had originally been established for one semester, the group unanimously requested an additional semester of meetings. Supervision of the psychologist was given by the clinic psychiatrist on the basis of one hour per two group meetings.

At the beginning of the program the teachers were told that the content of the

<sup>1</sup> Jersild, A. T., *When Teachers Face Themselves*. New York, Bureau of Publications, Teachers College, 1955, 3.

sessions was up to them, and that a minimum of direction would be given. The role of the group leader was primarily one of identifying underlying attitudes of the participants and using them as a basis for discussion.

## RESULTS

The kinds of problems discussed in the meetings have reflected the universality of some of the difficulties facing the new teacher. Four of these areas will be discussed. They are the teachers' relationships with authority, their expectations of themselves as teachers, their relationships with colleagues, and their relationships with children.

### RELATIONSHIPS WITH AUTHORITY

Evidences of authority problems have appeared throughout the course of the meetings, although the content, direction and expression of these problems have changed markedly. This has been noted both in the group's behavior toward the leader, as well as in the content of the material presented.

The group's identification of the leader as a member of the faculty and as a representative of authority in the college has become evident on several occasions and has been discussed as a factor inhibiting group movement. Despite the reassurance of confidentiality, it took a good deal of time for the group members to accept the fact that they would not be reported to college or school authorities or to their instructors for their feelings.

The group members have been unanimous in their conception of authority as critical, hostile and destructive. These attitudes have appeared particularly in relation to supervisory evaluations. On one or two occasions their attitudes had a strong basis in reality. Most frequently they did not.

Teachers who received glowing supervisory reports entered the conference with the feeling that they were about to be dismissed.

Another area involving authority problems was that of parent-teacher contact. Group members were initially quite frightened of any kind of contact with parents, fearing criticism and being reported to higher authorities. This came through most strongly during Open School Week, when parents visited the classrooms. The teachers felt that they were being observed through a critical eye, and that the parents were more concerned with the teachers' performance than with that of the children. The problem was further contaminated by the fact that in two situations the teachers' own mothers visited their classes during Open School Week.

Within the group setting, some of these attitudes have been traced to material outside of the school situation, particularly with respect to earlier attitudes toward parents and teachers. The teacher whose authority problems seemed most severe was one whose experiences with childhood authority had been critical and punitive and who was helped to recognize the similarity between the early and current situations. In addition, the fact that other people in similar situations shared similar kinds of feelings served as a reassuring mechanism, thus permitting more open discussion of these kinds of problems within the group.

As a result, authority problems did not come through in as severe a manner in later sessions as they did in the earlier ones. The focus of the problem seems to have shifted from "What does the authority expect of me?" to "What factors are inhibiting most effective classroom performance?" In this area, as in other areas of group consideration, the group has moved from seeking to obtain prescribed solutions to problems toward gaining increased understanding of

the factors involved in the determination of a given attitude or reaction.

#### EXPECTATIONS OF SELF

Generally speaking, the newly appointed teacher feels that unless she achieves perfection in all areas of functioning, she is a failure as a teacher. This has been consistently true with respect to material which has been discussed in the group.

In the first session one of the members described her difficulty with an extremely disturbed child who had problems in accepting limits. The feeling expressed by the teacher was that unless this youngster became an integral member of her class, she had failed in her duties as a teacher. When the more realistic factors of the situation were discussed and the fact became known that this youngster had a long history of emotional disturbance and school difficulty, it became apparent to the teacher that she was using this situation as a test of her own adequacy.

During the tenth session a similar situation arose with respect to this same teacher. It was apparent, from her knowledge of her class and from information given to her by supervisory personnel, that her class, from an intellectual and achievement point of view, was inferior to the other classes in the grade and had been organized in that way at the beginning of the school year. At the time of the city-wide achievement survey she expressed the feeling that unless this class compared favorably with the others in the grade, poor teaching ability on her part would be revealed. When the unreality of her expectation was pointed out to her by the group, she saw that this was another situation which was set up by her in terms which were impossible to realize.

When this same person brought up an analogous situation with respect to an overly demanding parent in a later session,

she herself said, "I suppose that what I'm expecting is out of line with what is actually going on."

This type of attitude has been generally true of the other group participants, and similar kinds of movement have been noted. One of the teachers commented on the importance of "looking at yourself first" when dealing with a problem to determine if the expectations have a realistic basis. In the meetings the majority of the group began to deal with discussions of problems from this point of view.

#### RELATIONSHIPS WITH COLLEAGUES

The group has also been a valuable medium for studying the teacher's relationships with colleagues, as manifested both in the school situation and in the group itself.

The problem, as it initially emerged in the first few sessions, took the form of constant comparison between themselves and more experienced teachers in their schools. This comparison ignored the experience differential and seemed to be used as further proof of their inadequacy. Thus, in the third session, when discussing the problem of group control, a group member compared her "discipline" unfavorably with that of another teacher in her school. Subsequent discussion indicated that the teacher in question had ten years of experience in the classroom.

In later meetings this problem was dealt with in terms of their conceptions of their roles as teachers. They considered materials relating to their early experiences with teachers as well as their perceptions of teachers' roles. One member of the group reported that she had always regarded teachers with awe and considered them superhuman. When placed in this role, she considered the other people in her school—that is, the "older" ones—as teachers, but



viewed herself as never being able to measure up to her childhood image.

Thus, it has become apparent that the beginning teachers in our group have viewed themselves, in terms of role, as being closer to the children than to the more experienced teachers in the school. In one instance a group member found herself having her former fourth grade teacher as a colleague, thus intensifying the problem from the reality point of view.

#### RELATIONSHIPS WITH CHILDREN

The aforementioned feeling of being closer to the children than to other teachers also manifests itself in the classroom problems of the new teacher. This has shown itself on several occasions. For example, in the fifth meeting one of the members described her difficulty in having her kindergarten group clean up following an activity period. The ensuing discussion brought out the feeling that "it isn't fair to have them do the dirty work." What became apparent was an indication that the teacher assumed that the children felt the same way about cleaning as she did, and that if she made this demand they would no longer like her. Subsequent to this session, the teacher reported that she discovered that the children actually enjoyed cleaning up and that it had been her attitude that she had attributed to them.

On a more general level it was clear that the group initially felt that it was essential to be liked by the pupils. Interpretation of this attitude by them brought about the realization that they experienced difficulty in setting limits for the class. They feared that setting limits would complicate their relationships with the children. It has become increasingly apparent to them, however, that their position reflected both their needs and their distortions of the problem and did not represent the needs of their youngsters in the classroom setting.

#### DISCUSSION

In this pilot project the feelings and attitudes of a group of newly appointed teachers were identified and explored through the medium of a psychotherapeutically-oriented approach. From the data obtained, it is evident that such a program requires the leadership of a clinically-trained individual as well as competent supervision, since phenomena of relationship common to other kinds of psychotherapies—for example, transference reaction and resistance—are present and must be dealt with therapeutically in order not to impede group progress.

Our results strongly suggest that many of the problems which manifest themselves in the classroom are reflections of more basic personality factors and that examination of these factors and the resulting increased awareness serves as a basis for growth and self-understanding.

Many of the diverse problems discussed by the teachers and presented here have their roots in basic problems of conscience. The teachers' strong burden of guilt and low self-esteem seemed to becloud their perception of reality. Thus, in one situation the teacher experienced excessive demands on the part of her supervisor; in another situation she made these demands on herself; and in a third situation she felt the children were requiring more than she was able to give them.

The participants in this project have reported it to be a valuable experience, not only helping to increase their classroom effectiveness, but providing insights into relationships outside of the school situations.

Due to the small size of the group and sampling limitations, the project will be repeated in the near future with another group of teachers. If the results are similar, it is anticipated that the materials will be used as a basis for discussion with teachers.

training personnel to help them gain increased insight into the emotional problems of the beginning teacher.

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DANA L. FARNSWORTH, M.D.

# Social and emotional development of students in college and university

Part 2

## INTERNATIONAL INTEREST IN MENTAL HEALTH OF STUDENTS

That interest in the social and emotional development of students in college is strong in other countries of the world was amply demonstrated in September 1956, at Princeton, N. J. At that time the International Association of Universities and the World Federation for Mental Health united in sponsoring a 10-day conference, attended by 37 delegates from 10 countries, at which all the major issues confronting colleges

and universities in the field of mental health were reviewed, some of them in considerable detail. The Grant and Field Foundations gave financial support, the chief executives of the two sponsoring agencies, as well as the executive directors of the foundations, attended the conference, and the writer of this report was the conference chairman. Delegates included educators, deans, chaplains, psychologists, students, public health experts, psychoanalysts and psychiatrists. The countries represented were Costa Rica, Mexico, Australia, Malaya, the Philippines, France, Holland, Great Britain, Canada and the United States.

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Dr. Farnsworth is Henry K. Oliver Professor of Hygiene and director of health services for Harvard University and Radcliffe College. The 1st part of this paper—covering the nature and scope of the student mental health problem and some experiences of college psychiatrists—was published in the July 1959 number of *MENTAL HYGIENE*.

Dr. J. R. Rees, director of the World Federation for Mental Health, had long been working to organize such a conference, but support was lacking for a number of years. He thought that recommendations



concerning mental health programs coming from the United States alone would not be received elsewhere with as much attention and receptivity as those emanating from an international conference, largely because of the universal tendency to assume that only the United States has financial resources sufficient to carry out such programs.

#### PURPOSE OF CONFERENCE

The conference was organized for the purpose of exchanging points of view of workers in different cultures, countries and types of educational institutions. A still more important reason was to determine whether there were any common principles or kinds of programs which would be recommended to educational institutions in all countries.

#### WHAT MENTAL HEALTH IS NOT

At the end of the ten days of exploration of the issues and problems involved, the delegates to the conference believed that enough general agreement had been achieved to permit the issuance of certain general recommendations to educational administrators and planners in all countries. Preceding these recommendations it was thought desirable to make it clear that although mental health cannot be defined in a simple universally acceptable manner, it is possible to make some clarifying negative statements about it. It was unanimously agreed that mental health is not characterized by adjustment under all circumstances, nor by freedom from anxiety and tension, nor by freedom from dissatisfaction, nor by conformity or constant happiness. Furthermore, the possession of mental health does not mean the absence of personal idiosyncrasies, a lessening of accomplishment or creativity or the undermining of authority, and it is in no way opposed to religious values.

#### RECOMMENDATIONS TO ALL COLLEGES AND UNIVERSITIES

The recommendations or resolutions may be summarized as follows:

1. The promotion of mental health in colleges and universities is the concern of every person connected with these institutions. The problem cannot be solved simply by supplying the counseling and psychiatric needs of some of the students, but rather by maximizing those factors within the institution which allow each student to reach his greatest potential growth, both academically and as a human being.
2. A mental health program should be geared to the usual educative processes of the institution. It may include service functions and teaching and should involve both faculty and students.
3. Training programs should be established in various countries, adapted to the special needs of the area in which they are located.
4. Special attention should be given to students who fail to complete their formal education, as well as those threatened by failure for emotional, social or cultural reasons.
5. Guidance programs of secondary schools and similar programs in the colleges should be more closely integrated in order to avoid sending out into the community so many embittered and frustrated persons who feel rejected by society.
6. By a variety of means, instruction in marriage and family living should be available to all students.
7. Research should be an integral part of all mental health programs.
8. Educational administrators, faculty members and students should have some awareness of the kinds of alterations of behavior

and thought in any given society or culture which indicate serious emotional disturbance requiring professional attention. Achievement of this goal requires a very tactful, thoughtful and widespread educational program.

9. Opportunities should be made available for faculty members to acquire the basic concepts of personality functioning that broaden understanding of the learning process and increase ability to aid the student in his intellectual and emotional development.

10. Factors in educational institutions that foster undue dependency, both those of environmental as well as those of inner psychological nature, should be studied continually.

11. Student responsibility for their education and conduct should be encouraged within limits, and the views of students should be heard and considered by faculty and administration.

12. Special attention should be given the lonely student although it is recognized that the student who prefers solitude is not a proper object for concern.

13. Special attention and study of the needs of the young married students is desirable.

14. Proper housing and other environmental needs are appropriate subjects for consideration by college and university planners.

15. The conference delegates deplored the development of curricula so crowded by formal studies, particularly in professional schools, that no time is left for participation

in activities making for a well-rounded educational experience.

16. It is an important principle of mental health that all human beings, regardless of sex, race, color or religion, be treated with equal dignity. Total discrimination on the basis of race, color or religion injures both those rejected and those in the institutions that practice such policies.

17. Severe overcrowding of college or university facilities produces serious psychological problems for many students. This is a very delicate problem, but a rapidly growing one.

All deliberations of the conference were recorded, and the material has been summarized and edited. This, together with selections and digests from about 30 papers submitted by the delegates prior to the conference itself, was published in the fall of 1959.<sup>1</sup> This volume should be most useful in stimulating interest in this field as well as in developing an increased awareness of how complicated and subtle is the problem of developing better mental health on a large scale.

#### POSSIBLE FUTURE DEVELOPMENTS

Future trends in this field seem to be discernible at the present time. There is a gradually increasing interest on the part of college presidents, deans and educators in teaching faculties about these emotional factors that accelerate or impede learning. There is increasing dissatisfaction with reliance on types of counseling that are confined largely to course information, career choice and testing for aptitudes or intellectual capacity, even though these activities are valuable and necessary. The need for applying knowledge gained from the newer studies in personality growth and development, as well as the consideration of factors which cause students to become ill and in-

<sup>1</sup> Funkenstein, D. H. (ed.), *The Student and Mental Health—An International View*. New York, World Federation of Mental Health, 1959.

effective academically, is becoming apparent to many educators. But how to apply this knowledge remains still an unsolved problem.

#### MANY DISCIPLINES INVOLVED

Many disciplines besides psychiatry have something to contribute to the solution of the task of integrating a consideration of motivation, emotions, unconscious factors and related matters into the traditional educational program of institutions of higher learning. The proponents of religion may assert that all would be well if only we would all believe as one. The anthropologists, the sociologists, psychologists and professional counselors all have much to offer. The educational psychologists, the psychoanalysts and the experts in human relations have definite and valuable ideas on what might be done. Clearly, some central concept or base of operation would be helpful.

Speaking as a physician who has worked in this field over a period of more than two decades, I believe that there are a number of possibilities, all dependent more on the interest, personality, training and capabilities of the individuals influential in the programs than on the particular system or scheme of operations. I have found that when the impetus for a mental health program comes from the health service, through its psychiatric division, and is wholeheartedly supported by the dean's office and other members of the college administration, the necessary coherence can be attained. My opinions will be based on my experience with this type of organization. At the same time, I am aware that other approaches might be equally practicable.

The approach to making college a more meaningful part of the student's life and to creating conditions that encourage the development of mature attitudes is by setting

up focal centers in each of the institutions that desire it—a small group of persons who see what issues are at stake and who will form the nucleus of a permanent in-service training program for all faculty members. Most members of such a group are already present in any college. The dean of students, the director of admissions, the director of the health service, the college chaplain and the chairman of the faculty committee on counseling are among the obvious choices for membership in such a group.

But these are not enough. The group needs one or more professionals, depending on the number of students, to give the needed emphasis to those many and varied aspects of individual behavior which have in the past been assumed to lie outside the scope of formal educational procedures. Assuming that this person is a psychiatrist, his work will consist in part of seeing individual students who are faced with personal problems, but more importantly in the long run he will consult with many other members of the college community, help in the resolution of educational dilemmas, and stimulate the interest of all who may have a latent curiosity about personality development. He will attempt to further the development of improved attitudes through group discussion, suggested reading of books and articles, and innumerable informal contacts of a casual nature.

Each college should work out its own program in terms of its resources, available personnel, needs, location and educational goals. The unifying factor of a body of theory and practice is rapidly being developed and will serve to keep individual colleges from getting bogged down in generalizations or from developing programs so diffuse that the participants do not know what they are doing.

Many colleges are now ready for such



a program and would encourage and support it. The limiting factor is the shortage of suitably trained psychiatrists, psychologists and social workers, particularly the former. On the other hand, many young psychiatrists are showing great interest in college psychiatry as a career, either on a full- or part-time basis. They need training and experience in this special field. Their stage of maturity and professional development is such that they cannot pay for this training, especially in view of the relatively limited financial return that they must anticipate from any educational institution after they assume their permanent positions.

### TRAINING PROGRAMS

The greatest need at present is the development of training programs for young psychiatrists, clinical psychologists and social workers who wish to enter the field. Several universities in the United States have developed psychiatric services as part of their health programs which are sufficiently effective and accepted to serve as training centers. Among these are the Universities of California, Wisconsin and Minnesota, the Massachusetts Institute of Technology, Yale and Harvard. Other institutions that are laying the foundations that could serve as possible training centers in the future are Cornell and Columbia Universities, the University of Pennsylvania and the University of Chicago.<sup>2</sup>

The large universities that are prepared to set up suitable training programs cannot afford to develop adequate centers without outside financial support. Supervision of trainees is expensive and should not be casually attempted. Combining the re-

sources available for psychiatric treatment of their students, usually derived from health service fees, and grants-in-aid to train young men and women in this field would result in advantages both for the training institution and those colleges which would later benefit from the experience of the trainees.

### PROFESSIONAL SCHOOLS

Coincidentally with the setting up of training programs in large universities and groups or divisions in the colleges that emphasize the social and emotional factors in students that promote integrity and maturity, some attention should be paid to the further development of theory in this field. A number of well-known and experienced older persons of great professional skill are available and eager to do this if they can have the necessary support. The dynamics that are involved in the development of the late adolescent and young adult form one interesting and vital area for extended study and research. The role of psychiatric ideas in the improvement of educational procedures is another field much in need of elucidation.

Another need which is closely related to the establishment of training programs is the development of combined programs of demonstration and research in a few institutions, designed to try various procedures which give promise of promoting better trained and more mature graduates. Among the procedures which should be tested for possible effectiveness are group discussions designed to bring out the varying ways by which strong emotions are expressed or affect behavior. How this idea might be explored we may describe in terms of a professional school curriculum, using a law school as an example.

Let us suppose that in this law school

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<sup>2</sup> Farnsworth, D. L., *Mental Health in College and University*. Cambridge, Harvard University Press, 1957, 173-80.

there are a very considerable number of persons who are vaguely dissatisfied with the results of three years of legal training on the students and who believe that a greater knowledge of personality factors of their clients and of themselves would help the students to become better lawyers. Arrayed against those who are discontented with the curriculum are a still larger group who believe that no changes are necessary, that the law should not become involved in matters of personality, that psychiatry cannot be a science since its borders and functions are so ill-defined, and that the thinking of modern dynamic psychiatrists is destructive of the legal process. Some faculty members may even say that since areas of common concern to the physician or psychiatrist and the lawyer form such a small part of legal education they may be safely disregarded.

The members of the group in the faculty who would like to see some of these problems explored learn that many students feel as they do about their training. They are concerned because so many students need individual psychotherapy to enable them to cope with the stresses they encounter in the school. Small groups get together and explore their common interests. They look for help but find that this is largely an unexplored field. They consult with the deans of the school and find that they too are concerned and willing to follow up the matter more intensively. They learn that many law students are seeking psychiatric help and that certain kinds of personality disorders seem to be more prevalent in law students than in those from other schools.

A young, well-trained psychiatrist is then found who comes to the law school as a member of the faculty and of the health service. He is not required to take on all students and faculty members as patients

who may wish his services. In fact, he is discouraged from doing so. Those who wish individual therapy may go to the health service psychiatrists or to private practitioners. He may do some individual treatment in some other setting than in the school itself in order to avoid loss of skill in this area.

During the first year, he studies the school and its curriculum, attends some classes, becomes acquainted with faculty members and student leaders, takes part in seminars or class discussions when invited to do so, tries to learn what the main sources of tension may be, and meets with any groups who may call on him for consultation. When he meets opposition he tries to understand it, learns from it when possible, and respects it, but does not protest in return. He works in close harmony with those psychiatrists who serve the community but does not get involved in patient-psychiatrist confidential relationships that would impair his usefulness in the law school.

Soon he finds that various groups of students would like some systematic consideration of the issues involved in human behavior when questions of criminal responsibility arise. Younger faculty members likewise have their interest stimulated. A few faculty wives may wish to organize an unofficial seminar on mental health problems. Consultants from other schools who have had different kinds of experience in the same field may be invited for a discussion of possible new developments and a comparison of results.

The direction such a program would take is unpredictable other than to say that it would undoubtedly lead to a reconsideration of many questions of vital importance in interpersonal relationships. Its success would depend in large measure on the attitude, skill, ingenuity, imagination and enthusiasm of the psychiatrist in charge.

In other professional schools modifications would be desirable consistent with the characteristics of the type of education desired. In at least four theological schools—Yeshiva University of New York, Loyola University of Chicago, Harvard Divinity School and Union Theological Seminary—programs are just beginning which are designed to explore the methods by which religion and mental health, or psychiatry, may collaborate effectively. Such cooperation is planned with the hope that graduates of these institutions will become more effective ministers than they could be without the skill and knowledge which can be derived from the study of mental health principles. Each of these projects is headed by a theologian or a psychiatrist with a member of the other profession as associate director. One project is supported by a private foundation, the others by 5-year grants from the United States government through the National Institute of Mental Health.

The Association of Medical Colleges is giving intensive consideration to the individual problems and development of the medical student. Counseling and tutorial programs are being examined with the view to vitalizing them by new concepts gained by recent studies of how students may be motivated most effectively.

Engineering schools, notably the Massachusetts Institute of Technology and California Institute of Technology, have been devoting major efforts to counseling programs, health services, psychiatric services, improvement in course offerings in the humanities and social studies, and student-centered activities (athletics and student government) all designed to produce graduates more mature and responsible than if they were simply well versed in mathematics, the sciences and engineering.

## TESTS OF MOTIVATION AND VULNERABILITY

If the general feeling and opinion of college psychiatrists that unsatisfactory family relationships and poor environmental conditions are important causes of illness and failure in college students, some methods should be devised to identify such individuals early in their college careers. This is especially true if such handicaps can be removed by individual counseling or psychotherapy. These students should be identified after their admission and appropriate measures should then be instituted, but they should not be screened out because of the existence of untoward family relationships. Many of our most productive citizens and most capable students have come from backgrounds with many presumably harmful features, but by a variety of circumstances they have reacted to such stressful situations by effective adaptations. Unfortunately, many more who are equally capable encounter circumstances more adverse than they can contend with successfully. Research to design appropriate tests for finding those most likely to be aided by individual attention is urgently needed.

When should a mental health program be expected to produce optimum results? Perhaps the beginning should be made in the kindergarten or in prenatal clinics with expectant mothers, or even in the late years of secondary school. Any argument as to which age is best for a beginning is rather pointless because from the practical point of view attention to mental health is needed at all levels of development. College students are in an excellent position to profit from a consideration of factors promoting mental health since they are confronted with so many possibilities and choices whose wise resolution is of utmost importance to them. They are also at the stage of either



having recently become parents or are in the process of selecting a marriage partner and hence have much potential interest in the conditions that favor the development of sound and healthy children. A college mental health program is easily integrated with other parallel programs at any stage of life.

#### NEW AND PROMISING EXPERIMENTS

The experience of the 420 students who were admitted to colleges with only two or three years of high school in 1951 under the auspices of the Fund for the Advancement of Education illustrates the fact that radical experimentation in varying educational procedures may be done without endangering the social or emotional adjustment of students, and may even facilitate their growth and development. These students were from one to two years younger than their classmates. They were admitted to 11 colleges widely differing from one another. They encountered expectations on the part of many faculty members, administrators and others that their age and social inexperience would produce a higher proportion of difficulties in terms of adjustment than in the rest of the student body.<sup>3</sup>

The entire group was investigated by psychiatrists who spend most of their time caring for the mental health of college students. The findings in the 11 colleges had numerous variations, but there was similarity in the fact that the students admitted early had no more psychiatric problems than their controls or the general student body. In most instances the percentage in this group experiencing difficulties was smaller than in the other groups. Psychoses occurred quite infrequently and from causes not dependent upon early admission. The test group made no more visits to counseling services than were made by comparison students. Visits to the medical services

were no more numerous than by other students. The group was no more "emotionally immature" than their classmates, and their rate of failure was lower than that of the comparison students or of the student bodies generally.

In general, the students admitted early desired counseling services on an individual basis, but resented any procedures that differentiated them from their classmates. They did not want any special treatment that set them apart. The only disadvantages they experienced had to do with dating for the boys and obtaining summer employment for the girls. A large number of these students felt that they had been favorably influenced in their social and emotional development and that they had escaped the harmful effects of boredom from lack of intellectual stimulation.

The Advanced Placement Program<sup>4</sup> is another experiment among those designed to loosen the hold of tradition that might be detrimental to educational procedures in this country. In this plan work is done at the college level by some of the more able secondary school seniors, examinations are given by the colleges, and the successful student is then granted credit for the courses thus completed when he enters college. The plan is steadily expanding. It has been helpful to students in keeping them working more nearly up to their capacity; their intellectual motivation is increased, and they get on to advanced college work sooner. To the teachers involved, both those in the secondary schools and in the colleges, new ideas and enthusiasm are generated, and the work of the schools and colleges has become better integrated with less duplication of

<sup>3</sup> "They Went to College Early." New York, Fund for the Advancement of Education, 1957, 46-59.

<sup>4</sup> Keller, C. R., "Piercing the Sheepskin Curtain," *College Board Review*, Fall 1956, No. 30.

effort. The movement is in the direction of stressing the individual and is thus a desirable counterpoise to the growing pressures toward quantity production in education.

#### NEW DIMENSIONS IN HIGHER EDUCATION

All these considerations confirm only too well the fact that those who are in positions of responsibility for planning the future of higher education in the United States are faced with many complex problems, some of them seemingly contradictory. They have too many young men and women to educate and too few teachers and facilities to do the job satisfactorily. Either new methods of teaching must be developed and new types of relationships between teachers and students encouraged, or rapid deterioration of the quality of college teaching and learning will follow. Emphasis on better salaries for faculty members and on building new classrooms and laboratories is necessary but, desirable as these goals are, even if won they will not solve many of the problems of higher education. Something new is needed, and urgently.

A new approach to the problem of higher learning in America will have influence on education all over the world. It is therefore exceedingly important that any concerted move made in American education be planned in such a way that adaptation to other societies and cultures be possible.

The new dimension of higher education that I consider to be in most urgent need of exploration is that of the role of emotions in education. One of the ubiquitous prob-

lems in relationships between individuals, between states or nations, and between races is that of the handling of hostility in such a manner as to avoid purposeless and chaotic destruction of human lives, and to develop instead attitudes of cooperation and reason. This can be done on a mass scale only by working through groups that are sensitive, influential and responsible. No more suitable group can be found than the large—but, statistically speaking, relatively small—segment of our population engaged in higher education. This includes both students and teachers. If their thinking is broadened and enriched by any new development, the attitudes of alumni of the various institutions will also soon be altered.

At the present time more than 3,600,000 students are enrolled in our institutions of higher learning. More than 42,000,000 young people are in our schools of all grades or levels. There are about 1,200,000 teachers in all our schools. Among the professional groups that keep in some communication with what is going on in our schools are 240,000 physicians (of whom only 10,000 are psychiatrists), 200,000 lawyers and 325,000 ministers. Any new and constructive move such as I have described that meets with the support of the majority of persons engaged in these broad fields of endeavor will very soon be reflected in altered attitudes, methods and procedures in the entire country.

The size of the task appears overwhelming, but the need for its accomplishment justifies an attempt by all the resources at our disposal.

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ARTHUR L. BEELEY, Ph.D., LL.D.

# Alcoholism, social work and mental hygiene

When we say that alcoholism is an illness, do we imply that the "illness" can be the illness only of a person? Is it not possible that a society also can be ill?

I shall argue that alcoholism can be both the illness of a person and the illness of a society. There is a valid axiom of social psychology which aptly describes the relationship of the individual to his cultural group, as subject and as object. The inseparability of these two facets is suggested by the metaphor that they are like the two sides of a coin. This principle is tersely expressed in the intriguing title of a recent book, *The Juvenile in Delinquent Society* (1).

A few months ago I spent some time in New York City observing at first hand the activities of the New York City Youth Board and discussing the evaluation of its activities now being made by Dr. Robert M. MacIver, a distinguished sociologist of Colum-

bia University. He said the board had just completed a study of juvenile delinquency among Puerto Ricans, and had found that it is 12 times greater in New York City than on the island of Puerto Rico itself! Can society be sick? Yes, indeed. And if our logic is sound and our assumptions correct, sick societies produce sick people.

In our past and present thinking about human behavior we have been too greatly influenced by two general ideas: first, the belief in a free will; and second, the prepotence of heredity. Even today most people only grudgingly admit the influence of environment and of our social institutions

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Dr. Beeley is dean emeritus of the Graduate School of Social Work at the University of Utah and a Fellow of the American Orthopsychiatric Association. The paper is an expanded and revised version of his lecture June 27, 1958 in Salt Lake City at the 7th annual session of the Utah School of Alcohol Studies.



upon personality and character. This influence, sometimes for good, sometimes for ill, is apparent to all unprejudiced observers. It is also an axiom of social psychology that one of the major factors in social disorganization is the accelerating tempo of social change, especially as seen in large industrialized centers which intensify anonymity in human relationships.

At this point let me call attention to two books which amplify the view I am here advancing. The first is a study by Frank, a distinguished group therapist, entitled *Society as the Patient* (2). The other is a more recent book by Fromm, a psychoanalyst, *The Sane Society* (3), in which he discusses the pathology of normalcy, the roads to sanity, etc.

Perhaps the most convincing study which has appeared since World War II is the epidemiological survey made by the Scottish psychiatrist, Halliday, whose brilliant researches are reported in *Psychosocial Medicine* (4). He considers Great Britain as a "sick society," as evidenced by the recent phenomenal increase in the "psychosomatic affections." As a result of his intensive study of the coal-mining community in Britain, he thus proves his thesis convincingly.

But you might ask at this point: Are you trying to argue that sick societies intensify the problems and consequences of alcoholism? Yes, indeed. Moreover, I am convinced, *a priori*, that if we made extensive epidemiological studies in this country, of the sort made by Halliday in Britain, we would discover an equally sharp rise in the frequency and extent of psychosomatic ailments in the general population and an even sharper rise in the pervasiveness of addictive alcoholism.

## LANDMARKS IN SOCIAL MEDICINE

Permit me at this juncture to make a brief detour and to share with you some ideas

which have formed part of my lectures to medical students at the University of Utah. Knowing how hard-pressed the average medical student is to find time for outside reading, I first call his attention to two unusual books, both written by eminent physicians. The first is *Civilization and Disease* by Sigerist (5), a genuinely profound study. The second is an equally brilliant study by Cobb, *Borderlands of Psychiatry* (6).

In his monograph—a superb manual not alone for the professional, but for the quasi-professional worker as well—Cobb points out that the hard core of psychiatric medicine comprises the approximately 700,000 hospitalized patients suffering from mental disease; and the approximately 100,000 institutional cases in the mental defective population in state schools. On the periphery of this institutional problem are some 3 to 5 million "dements" and "aments" who are unhospitalized. On the borderland of these problems, however, are the less serious but more frequent mental illnesses known as the psychoneuroses, epilepsy, stammering, alcoholism, etc.

Cobb conservatively estimates that in 1943 some 1,600,000 men and women in the United States were definitely "injured" by alcoholic intoxication. These are the people, he says, who can neither get along with liquor nor without it. A revised estimate, using Jellinek's formula, however, indicates that Cobb's estimate is altogether too conservative. In 1955 it was estimated that there were 4,712,000 alcoholics in the United States—4,002,000 men and 710,000 women—giving a sex ratio of 5.6 to 1. This is an increase of 50% since 1940 (7).

My chief point in addressing medical students, however, is to indicate the historical landmarks in social medicine. There is an ancient belief which has persisted for centuries (and is still naively believed by many today) that the human organism is like a

machine; and that if the body fails to function properly, the cause must perforce lie inside the body. In speaking of the relationship between mind and body, the field now known as psychosomatics, Cobb quotes from the dialogues of Plato in 380 B.C.: "For this is the great error of our day in the treatment of the human body, that physicians separate the soul from the body." It was not until the beginning of the 20th century, some 2,300 years after Plato, that many human maladies, including certain mental disorders such as those which Cobb lists as "borderland" (for example, alcoholism), were forthrightly regarded as psychosomatic in nature.

Another landmark in social medicine was achieved in 1909 when William Healy, a neuro-psychiatrist, organized the Juvenile Psychopathic Institute in Chicago as an auxiliary to the first juvenile court in America. The uniqueness of his enterprise was his demonstrated belief that the psychiatrist must work closely with the clinical psychologist and the social worker in diagnosing the individual delinquent. Thus was created the first interdisciplinary team. It has since become the prototype of most, if not all, child guidance clinics in the western world.

It was not long thereafter, so the record goes, that the late philosopher John Dewey, in addressing a meeting of the American College of Surgeons, commented on the conventional goal of modern medicine and surgery ("a sound mind in a sound body") by suggesting that this objective be expanded to read: "a sound human being in a sound human environment."

Perhaps the statement which best defines the goals of social medicine is the one formulated in 1950 by the World Health Organization, an auxiliary of the United Nations Organization, which defines health as "a state of complete physical, mental and so-

cial well-being; and not merely the absence of disease or infirmity."

In the light of the foregoing, may I now suggest that the broadest conception of alcoholism is to regard it as a socio-psychosomatic illness.

## SOCIAL WORK AND MENTAL HEALTH

Before we discuss the question: "How does the social worker deal with the alcoholic?" let me comment briefly on the field of social welfare *per se*. Modern social welfare, broadly defined, comprises all of the arrangements, both public and private, for helping needy persons of every variety and from whatever cause; it is a non-political, non-sectarian enterprise, administered by an ever-increasing body of professionally trained men and women who believe that the social ills of our time will yield to an unselfish, intelligent, cooperative attack.

Social work long ago took its place among the other helping professions because it satisfies an indispensable social need and is based upon a body of specialized knowledge tested by experience. While it is based upon well-established scientific principles, it is, nevertheless, an art, in that it requires the exercise of discretion and judgment. Like the other helping professions, it recognizes its primary obligation to its clientele; hence its members are guided by an accepted code of ethics. To a very great degree it is an interdisciplinary endeavor; yet its uniqueness lies in its own differential methods, case work and group work. Its secondary methods include community organization and administration. Like all other professions, it uses such ancillary processes as research and communication.

Professional social workers are no strangers to the problems of mental disorder and mental health; their education in the behavioral sciences and their training in so-

cial psychiatry—especially in preparation for such specialties as psychiatric social work, orthopsychiatry and corrections—qualifies them to play an increasingly important role in this major field of endeavor. Moreover, they are sensitive to the fact that the ultimate solutions depend more upon the methods of prevention than the techniques of cure.

From their knowledge of the mental hygiene movement, they remember too that three of its founders were dedicated laymen: William Tuke (1732-1822), the Quaker who established the Retreat at York, England; Dorothea Lynde Dix (1802-1887), whose humanitarian zeal gave us the state hospital system of care in this country and abroad; and Clifford Whittingham Beers (1876-1943) whose autobiography, *A Mind That Found Itself* (8), dramatically ushered in the national and later the international movement now known as the World Federation for Mental Health. This does not, to any degree, denigrate the profound contributions of the medical pioneers—Pinel, Rush, Charcot, Freud (and his brilliant disciples), James, Meyer, von Jauregg, the Menningers and others.

### THE ART OF FACING REALITY

I want now to deal with some basic ideas in mental hygiene which I frequently discuss in university lectures. The caption, The Art of Facing Reality, helps one, I believe, to see both the positive and the pathological aspects of the matter in proper relation.

It is a truism of social psychiatry that in the relentless process of living, personalities sometimes become warped or distorted. If the pressure of the environment is too intense or the organism is constitutionally (or momentarily) weak, the personality may warp or even disintegrate.

The nature of this process has been aptly phrased by Samuel Butler in the following

excerpt from his well-known satirical novel, *The Way of All Flesh*: "All our lives long, every day and every hour, we are engaged in the process of accommodating our changed and unchanged selves to changed and unchanged surroundings; living, in fact, is nothing else than this process of accommodation; when we fail in it we are stupid, when we fail flagrantly we are mad, when we suspend it temporarily we sleep, when we give up the attempt altogether we die."

How do people customarily face such routine realities as the day-to-day problems of illness, disappointment, grief, etc.; the chronic failures in employment, in family life, marital relations, etc.; the gnawing feeling of inferiority; "success" in all its forms, "power and glory" arising from wealth, position, rank, authority; the "triumph and disaster" impostors of Kipling's "If," etc.?

What, then, are the general characteristics of mentally healthy people? In the absence of an authentic definition, I submit that the mentally healthy person is one who customarily faces life's realities at the proper time and in a socially approved way. Such people are emotionally stable, we say, and their peace of mind is a by-product of self-knowledge.

There are, of course, three general patterns of escape from the stresses and strains of daily life. The first may be called "harmless," and includes that endless array of diversional activities such as play, travel, amusement, etc. The second category comprises those activities which can be called "helpful," and includes all re-creative activities, avocational pursuits, hobbies, etc.; to many people, vocations and religious activities also constitute "helpful" energizing escapes from stress.

The third pattern of escape includes all of those "harmful" evasions which lead away from mental health; together, they



make up that omnibus category, "mental illness," in one form or in one degree or another:

- Chronic procrastination and the "paralysis of hesitation."

- Re-defining the social situation by rationalization, self-justification and blaming others or by falsification, misstatement and lying.

- Putting the matter "out of mind" by changing the appearance of reality by means of alcohol, narcotics, tranquilizers, etc.; by repression or dissociation; by escape into psychoneuroses (anxiety attacks, psychosomatic-system reactions, depressive reactions, hysteria, obsessive and compulsive reactions, etc.); by escape into fantasy hallucinations, delusions, disorientation and other psychotic symptoms); by sociopathic and psychopathic "acting out" escapes, arising from hostility and aggression, resulting in violence, crime or delinquency.

- Running away, as in truancy, desertion or wandering, and in suicide, the irrevocable escape.

#### SOME PRINCIPLES OF MENTAL HYGIENE

Offsetting the foregoing inventory of "harmful evasions,"—a somewhat melancholy list, to be sure—are the following prophylactic principles of mental hygiene. It is a short catalogue of axioms and lays no claim to finality or completeness:

1. Activity is the normal characteristic of personality; physical and mental inactivity are pathological.

2. Mental poise is facilitated by an alternating program of work, rest and play.

3. The differences between personalities are so great as to make it dangerous to prescribe the same treatment for all individuals.

4. Almost all persons have some degree of inferiority feeling; compensations for actual or imagined inferiority are quite normal. The problem is to derive appropriate compensations.

5. Every person should experience success or superiority in some field or situation with sufficient frequency to prevent the development of an inferiority feeling.

6. Many personality problems are overcome when the handicapped person is able, through the assistance of others, to objectify his own difficulty as though it were the problem of another.

7. Man's ego is normally shaped and held within bounds by the attitudes and responses of others, a dynamic process of interaction aptly suggested by the poet Burns in the famous couplet: "Oh wad some power the giftie gie us, To see oursel's as ithers see us!"

8. Energies, instincts, emotions, impulses, etc., cannot be successfully repressed; they may, however, be sublimated, that is, reconditioned to constructive ends. (In a recent report, *Evaluation in Mental Health*, the following statement appears: "... personal values, professional judgment and evaluative research studies yield a consensus of evidence that gratification and affectional relationships are superior to deprivation, rejection and severe frustration in the development of a healthy personality" (9).

9. All persons, at one time or another, normally need a confidant, that is, some understanding person who will listen without moralizing. Herein lies the cathartic value of companionship, prayer, the confession, psychiatric treatment, group therapy, membership in "Alcoholics Anonymous," etc.

#### ALCOHOLICS ANONYMOUS

"A.A." is a socio-psychological invention of great significance, for it demonstrates the

powerful dynamic of the small, intimate group where there is harmony, rapport and empathy. The spontaneous origin and spread of the movement attests the need it meets in the alcoholic whose first victory is his admission that he needs help; and second, his identification with a peer-group in the same predicament.

The "anonymous" aspect of the group is a double guarantee of secrecy and confidentiality, plus immunity to the two social institutions towards which the alcoholic may be hostile: the church, which moralizes, and the law, which punishes.

Another strength of the movement is its ability to remain informal and unstructured, and to resist the American tendency to expand. (See also *Alcoholics Anonymous Comes of Age* (10).

#### EDUCATION AND RESEARCH

What is greatly needed in our public schools is a comprehensive program of mental health and character education—not alone as a specific preventive of alcoholism but as a general prophylaxis against the pervasive stresses of the atomic age. Moreover, there is no enterprise of any consequence that cannot be enlightened by research. The *Quarterly Journal of Studies on Alcohol* is a symbol of this approach. However, I predict that the social and behavioral aspects of alcoholism will receive vastly more

attention in the future than they have in the past.

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P. STEFAN KRAUS, M.D.

EUGENE MITTELMAN, M.D.

# The impact of phrenotropic drugs on hospital psychiatry

Phrenotropic drugs represent the latest form of treatment available for the hospitalized mental patient. Unlike other recent modalities of somatic therapy, such as insulin coma and electric shock, the phrenotropic drugs have made a profound impact on the structure and goals of the mental hospitals. The effects have reached even beyond the hospital into the community, influencing the whole conception of mental illness and how it should be treated. This development and its consequences is paralleled only by Pinel's breaking of the chains and Freud's insistence that mental illness can be understood and treated. For the first time, the patient, his relatives and the public at large have witnessed profound changes in mental symptomatology produced by external intervention. Even if cure has not been achieved, the expectation that someday this might be within our grasp has certainly been kindled.

The purpose of the present paper is to

examine the effects of the large-scale use of phrenotropic drugs on the patient's view and attitude towards the hospital, on the hospital-patient relationship, on hospital personnel, on the patient's family, on rehabilitation objectives and finally on the hospital climate.

Before these topics are developed, some general remarks on the direct effect of drugs on patients, chiefly the schizophrenic group, are necessary as a background.

## EFFECTS OF THE TRANQUILIZING DRUGS ON PSYCHOTIC SYMPTOMATOLOGY

From the outset, it should be stated that the drugs have proven no cure-all. In patients with depression without agitation, results

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Dr. Kraus is director of professional education and Dr. Mittelman chief of acute intensive treatment service at the Veterans Administration Hospital in Bedford, Mass.



have been disappointing. Only a relatively small number of long-term patients have been discharged from the hospital "completely recovered" purely as a result of drug treatment. A larger percentage can now be carried on trial visit status, needing some, however tenuous, tie to the hospital. We find that while schizophrenic patients show improvement, they still exhibit limited initiative and spontaneity, and though they are more friendly and pliable, their basic emotional tone often remains essentially unchanged.<sup>1</sup>

In spite of these limitations, the drugs have produced drastic changes among the patient population of the mental hospital. Without doubt, the drugs have a physiologically quieting effect on the patient; he not only seems calmer and less disturbed by his environment, but objectively reports that he feels more at ease. Most important, the patient receiving a tranquilizer does not lose his responsiveness to the environment, in contrast to the patient receiving a barbiturate, which is in a sense, a chemical straight-jacket. Beyond tension reduction, the tranquilizing drugs may often have other physiological stimulating effects.

Clinically, tranquilizing drugs check motor excitement, agitation, noisiness and assaultive behavior. Control of tension and anxiety in turn reduces the patient's need to engage in attention-getting behaviors such as meddlesomeness, clinging, repetitive mechanisms or pathological fault-finding. Furthermore, inhibitory states such as catatonia and negativistic attitudes are overcome. As a consequence of these effects the patient shows less preoccupation with internal phenomena and pressures. He does

not need to channel all available energy into autistic self-observation, which often results in distortions of reality with attendant, bizarre delusions or hallucinations. Instead, his attention is more easily directed towards the environment and he appears better organized. Thus, he shows more interest in self-care, such as cleanliness, food intake, physiological body needs, and becomes more reliable in handling privileges, work assignments and financial matters.

#### CHANGES IN THE PATIENT'S VIEW AND ATTITUDE TO THE HOSPITAL

Perhaps the most important consequence of the use of the drugs has been the radically different impression which the patient has of the hospital upon admission. To begin with, the pre-hospital use of tranquilizing drugs has meant that fewer patients now arrive at the hospital in states of acute excitement, confusion or panic so characteristic of former admissions. Those already treated with drugs, even though unsuccessfully, are apt to look upon the hospital as a place where their previous therapy will be continued and intensified.

Patients who are admitted in acute, excited states regain some equilibrium much faster with this new medication. We less frequently encounter lengthy confusional states which formerly led patients to misinterpret the methods and purposes of a mental hospital, resulting in early attitudes of resentment, hostility and strong disposition to non-cooperation. Furthermore, they no longer are frightened by rumors of drastic treatments, such as electric shock, insulin coma and lobotomy as being the major treatment modalities in the hospital. The prescription and administration of drugs, as well as regular laboratory work-up now parallel the more familiar experience of a general hospital. Thus, they are not as likely to feel mystified when admitted to a

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<sup>1</sup> This fact has led some psychoanalytic psychiatrists to voice reservations in the use of tranquilizing drugs, insisting that overcontrol of anxiety interferes with effective psychotherapy.

mental hospital and they more readily accept hospitalization, although originally they might have been against it.

What are the consequences of this development? First of all, many patients are more tolerant of initial restrictions which the hospital might find it necessary to impose. Secondly, they are more willing to cooperate with the hospital in matters of commitment. When patients were not expected to understand the necessity of hospitalization, they looked at it negatively, chiefly as confinement, with the result that involuntary commitment through the courts was practically routine. Understandably, commitment entails possible unpleasant repercussions and stigmatization, affecting such matters as civil rights, driver's license and future job opportunities; it may even endanger the patient's previous position in the family.

Since the advent of phrenotropic drugs we have been able to carry most patients on voluntary commitment. This reflects a favorable view of the hospital by the patient and eases general administrative features such as the granting of privileges and the conduct of activity programs.

In regard to privileges one could say that the most difficult adjustment that a patient has to make to hospitalization is his often protracted loss of freedom of movement. This no doubt is related to the great emphasis that our culture places on the value of freedom and self-reliance. With the use of drugs we have found that patients can be depended upon to handle ground privileges very early in their hospitalization. This not only prevents much resentment and irritation by the patient but also promotes in him a feeling of trust and responsibility.

In the case of activity programs we find that many more patients are willing and able to participate in some form of activity, rehabilitative or simply recreational. In fact, many of our facilities have been sev-

erely taxed to meet the demand by the patients to be occupied.

#### CHANGES IN HOSPITAL-PATIENT RELATIONSHIPS

One of the chief problems of any large psychiatric hospital is to provide care and supervision for many hundreds of patients. Moreover, it is well known that most of these hospitals are operated with a relatively small professional staff. In contrast to private practice, where the emphasis is on the study and treatment of intrapsychic features of the patient's disturbance, the professional staff of the large mental hospital has had to search for other therapeutic resources and techniques beyond individual therapy to reach the great majority of their patients. One result of such efforts was the awareness of the clinical significance of socio-environmental factors in the mental hospital setting.

Viewing the hospital as a subculture (containing socio-cultural factors and functions) has led to remarkable improvement of patient care and treatment. For example, many time-honored hospital stand-bys, such as restraints, seclusion rooms, hydrotherapy, "closed" wards, etc., have been drastically reduced or even abolished. While the professional staff welcomed these developments, there still remained the hope and expressed need that more individualized attention for patients might someday be possible. The phrenotropic drugs have unexpectedly provided us with the opportunity to give individualized treatment to large numbers of patients. Since drugs have to be prescribed, administered and readjusted on a day-to-day basis, it follows that the patient has to be treated as an individual.

This *de facto* recognition of the patient as an individual, always the announced goal of the therapeutic milieu, is illustrated during daily rounds when doctors and

nurses make solicitous inquiries of the patient as to how he "feels," often relying on his own evaluation as a gauge of improvement or side effect of the drug.

This contrasts with the former attitude of hospital personnel towards the patient's account of somatic sensations, most of which were given little actual weight, being solely interpreted as projected expressions of interpersonal conflict into body language. While this insight is still valid for understanding the dynamics of the patient, it has always remained of limited practical value in the hospital setting where there was no way to follow through in psychotherapy. Thus, in effect, the personnel operated in a different frame of reference from the patient, who consequently felt misunderstood, neglected or even hurt. Now, with the experience that at least some of his physical symptoms are given actual consideration, it is easier for the patient to feel understood.

This personalized contact with the patient is also evident in relation to voluntary commitment. Not infrequently during the course of their illness, patients may demand to be discharged before being ready for it. Handling such requests calls for much tact, skill and flexibility by the personnel. It is to be recognized that this places additional strain on the personnel, yet ultimately makes for more genuine interaction which the patient recognizes and appreciates.

In the light of these developments in hospital-patient relationships, it is only natural that we should re-examine in detail the changes in the role of key professional personnel in the hospital.

#### EFFECT OF DRUG THERAPY ON HOSPITAL PERSONNEL

Hospital personnel have been affected in two ways by the extensive use of phrenotropic drugs. On the one hand, professional groups such as psychiatrists, nursing per-

sonnel, social workers and psychologists have felt the need to redefine their role in respect to the patient as well as in relation to each other. On the other hand, there has occurred a shift of emphasis as to the contribution of various hospital departments and services to patient care.

#### THE PSYCHIATRIST

In discussing the changing role of the psychiatrist we must first note that he has been traditionally in short supply in the mental hospital, and present trends indicate that there are no real changes in the offing. Moreover, most psychiatrists have been largely utilized for "medical-administrative" purposes (annual physicals, night duty, medical emergencies, processing records, classification of patients, insurance and compensation reports, preparation of abstracts, and coordinating functions). In planning his work the psychiatrist was apt to give precedence to medical-administrative urgencies over purely therapeutic, time-consuming contacts with patients. Because of varied commitments the psychiatrist maintained only marginal, often only token, contact with the patient.

He therefore welcomed recent trends which brought about a decentralization of patient care, which gradually came to be looked upon as a joint enterprise of many specialized departments, such as social service, vocational counseling, physical medicine, and rehabilitation with its many "clinics" and varied "therapies." However, since these departments also had only marginal contact with the patient, the concept of the psychiatric team was developed in order to round out a whole picture of the many facets of which a patient's personality, problems and difficulties were reputedly composed.

As noted earlier, large-scale use of phrenotropic drugs have made more direct



demands on the hospital psychiatrist, requiring him to have almost daily contact with the patient, to map out his progress step by step—in relation to drug dosage, to his hospital program, to his plans for the future. Since delegation of these functions is not easy, the psychiatrist is forced to assume a more active, central and therapy-oriented role with the individual patient instead of being purely a ward manager and nominal captain of the team.

It is interesting to point out that this development came just at a time when some hospital psychiatrists began to embrace dynamic concepts and were ready to acknowledge that patients could be helped in other ways besides external intervention and manipulation. These psychiatrists began to look upon themselves more as agents intent on the mobilization of the patient's own inner resources, by keeping involvement and external intervention at a minimum. They tried to modify this ideal role to some extent in order to meet the practical demands of actual hospital practice.<sup>2</sup> Just when a satisfactory balance between a directive and a non-directive role seemed to be achieved, the equilibrium became upset with the advent of phrenotropic drugs and once again the hospital psychiatrist became committed almost exclusively to methods of external intervention.

This has had several consequences. The most important one, from the patient's point of view, concerns the well-known disposition to endow the psychiatrist with magical powers inherent in all medical practice. The patient is only too ready to rely upon magical forces and external intervention in preference to a more prolonged and painful therapeutic process. It becomes incumbent upon the psychiatrist to strike a healthy balance between applicable dynamic concepts and taking proper ad-

vantage of the new drugs which, after all, are the prototype of external intervention.

#### NURSING STAFF

In the case of nursing personnel we find that the function of the psychiatric ward nurse is also changing. Just recently she has been urged to carve out for herself a psychotherapeutic or socio-therapeutic role with respect to patients under her care. We now find that she has to return in some respects to the traditional duties and functions of the nurse. Not only is she busy much of the time administering drugs, but in addition the ward physician has come to rely upon her to watch for possible medical side effects and to help him evaluate results of the therapy.

The more sophisticated, dynamically oriented nurses are reluctant to shift the emphasis of their contribution to patient care, while other nurses have been especially gratified to know that patients now are actively receiving treatment which they themselves can understand. Previously, despite all training efforts, many nurses had remained mystified and unconvinced as to how the psychiatrist was attempting to help the patient. One of the challenges for psychiatric nursing will be to integrate the socio-therapeutic notions with the functions of the traditional nurse.

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<sup>2</sup> One might think, incidentally, that this dual function might have a unifying influence on the previously deeply split schools of the organicist on the one hand and the strictly dynamically oriented psychiatrist on the other. As both schools approve the use of drugs, we note that the former has wholeheartedly welcomed these new treatment opportunities at the expense of dynamic concepts, while the latter has been giving them reluctantly—pointing out that the drugs merely serve to increase psychotherapeutic opportunities. Thus both schools attempt to retain, if not to reinforce, their original orientation.

## PSYCHOLOGIST

The psychologist has been a relatively recent addition to the mental hospital organization. His role has been of a varied nature. Originally he was engaged primarily in psychological testing, chiefly for diagnostic purposes. Over the years he has assumed additional functions such as research and psychotherapy, and of late he has made useful contributions as a social scientist. He has been considered a member of the therapeutic team.

As the need for diagnostic refinements diminishes and as individual psychotherapy becomes less practical or economical in the large mental hospital, especially with the recent tendency of rapid patient turnover, a new role has to be assumed by the hospital psychologist. In addition to his contributions as researcher, individual and group therapist and social scientist, he could perhaps best serve the hospital by taking over certain administrative functions in connection with the ward organization, freeing the psychiatrist for more actual therapeutic duties.

## SOCIAL WORKER

The social worker has always been the connecting link between the hospital and the patient's family. In order to study the social background of the patient, much of the social worker's efforts were spent on time-consuming home visits designed to appraise the family constellation in its own surroundings. The social worker would also spend many hours interpreting to the family the long-range nature of the patient's illness, the paucity of our treatment armamentarium and the nature and goals of a mental hospital.

With the shortened duration of the patient's illness and the more ready acceptance of the mental hospital, this particular func-

tion of the social worker has lessened. Rather, with the arrival of drug therapy, there arose an urgent need for prompt and continued contact with the family (and often with the employer). To meet this demand our hospital has added a resident social worker to the admission ward. This was done not merely as a convenience permitting the social worker more effective use of her time than might be achieved by home visits, however desirable these might be. It was found that special benefits resulted from ready communication between the social worker, the family, the ward physician and the patient. Thus, the social worker can be utilized more effectively to deal with basic attitudes arising within the matrix of the family and affecting the patient.

In this way the patient's return home can be materially speeded up and the family can be helped to accept the patient's striving for a greater measure of independence. Furthermore, the social worker is valuable in arranging meaningful psychiatric follow-up upon the patient's release.

## DRUG THERAPY AND THE PATIENT'S FAMILY

The effect of drug therapy on the patient's family has been very rewarding. Often families have already heard of this new treatment from the newspapers, and they are apt to insist that the patient be tried on medication.

We have observed definite changes in the family's relationship to the hospital purely as a result of drug therapy. In the past, families often tended to shy away from psychiatrists and social workers because of the implication—part of our present culture—that the family is in some way to blame for the patient's sickness. This engendered in the members of the family closest to the patient certain feelings of

guilt and shame often motivating them to justify their position with the hospital. Frequently they have felt under pressure by the hospital staff.

With less stress on interpersonal causation of mental illness and greater emphasis on the varieties of treatments available, the hospital personnel meets the family in a more relaxed fashion; the family in turn appreciates being continually informed and in the picture in regard to the patient's treatment and progress. As a result, they are often desirous to be helpful to the hospital. They are prepared to continue contact with the patient either by regular hospital visits or by allowing frequent home visits. They also are disposed to make allowance for the patient's unpredictable behavior. This latter situation is easier since the drugs do much to minimize the type of behavior which families might find most objectionable.

The drugs have helped the family from the start to be more hopeful regarding the patient's prognosis. Rather than visualizing the illness as the start of a prolonged and often hopeless disease process, they now can look upon the patient's disturbance as nothing more than an episodic occurrence.

#### DRUG THERAPY AND REHABILITATION CONCEPTS

The term *rehabilitation* in its widest meaning connotes restoration of a condition to a former state of functioning. In this sense, all efforts in behalf of patients, both psychiatric and medical, can conceivably fall into the province of rehabilitation.

In its more specific sense the term *rehabilitation* is applied to methods and goals of various modalities of activity and "treatment" offered by specialized departments in a mental hospital such as occupational therapy, industrial therapy, manual arts ther-

apy, educational therapy, physiotherapy, etc.

Originally, the model for psychiatric rehabilitation was taken from experience gained in working with the physically handicapped, in whom long periods of retraining are common (the origin of this concept is even shown in the name of the Department of Physical Medicine and Rehabilitation).

Large-scale use of tranquilizing drugs has made it clear that mental illness does not necessarily follow the course frequently observed in the field of physical medicine. Psychotic patterns are as often resolved by "crisis" as by "lysis"; that is, sickness and improvement may occur by sudden rearrangements of the mental "set" rather than by slow symptom-by-symptom progression.

Yet the notion of a slow and gradual convalescence has profoundly influenced our thinking in the field of psychiatric rehabilitation. Thus, in line with this gradualistic view, arose certain procedures and practices, the most important of which perhaps is the rehabilitation "team."

The team is composed of representatives of various services in the hospital and usually includes the ward physician, the psychologist, vocational counselor, members of the physical medicine and rehabilitation service, a nurse and a social worker. These services are considered to represent separate disciplines. A major function of the team is to avail the patient of its varied skills in an integrated manner.

It is to be recognized, however, that even though each team member considers himself a representative of a separate discipline with specialized professional methods, techniques and insights, in reality these services are only subdivisions of one discipline—namely, the medical-psychiatric—and thus cannot be compared to interdisciplinary teams applicable in other scientific fields.

The team approach does certainly facili-



tate communication among the services concerned with patient care. However, it can work only if the contribution of each member is carefully weighed as to its significance. While in theory it is understood that the services are not of equal value, in practice there is frequent tendency to give everyone equal voice in evaluating the patient and planning for him. The implication is that a democratic resolution is also a therapeutic one.

The formalized psychiatric team is chiefly concerned with long-range planning for the patient. Patient movement being slow, there is no need to arrive at rapid decisions since at each stage the team can avail itself of prolonged periods of observation. As a consequence we may find a tendency to stress the specific contribution of team members, often leading to professional status problems with the possibility of losing sight of the patient's own adaptive resources. Furthermore, caution, sharing of medical responsibility and team communication may be overemphasized, while the patient often has a chance to solidify his symptoms.

In line with slow patient progress, cumbersome and detailed administrative routines were developed in respect to hospital work assignments, vocational planning, ground privileges, passes, trial visits and discharges. Not long ago most hospitals held staff meetings before many of these decisions could be made. The delay often actually retarded the patient's progress. It is even clearer now, with the use of new drugs, that this is the case. Briefly, it has been our experience that the team's chief rehabilitation challenge is to quickly adjust to the patient's needs without lagging behind more than necessary. While in the past the hospital personnel waited for the patient to improve, it appears that now the patient must wait for the personnel to adapt to his needs.

It must be stated that even before the use of tranquilizing drugs we witnessed a gradual shift of emphasis in the facilities used in our rehabilitation program. For instance, physiotherapy was reduced to a minimum. Wet sheet packs, tubs and other forms of hydrotherapy are today only of historical interest.

The usefulness of educational therapy and industrial retraining as such have been questioned for some time, since in practice few patients have availed themselves of these long-range retraining facilities. Educational therapists themselves have recognized this and they now talk more about "therapy through education" than "education through therapy." One reason for this impasse is that very sick patients do not have the interest, attention span and long-range planning ability to pursue such complex programs. The improved patient, on the other hand, who could use such facilities, usually prefers to receive training outside the hospital—a desire which should, of course, in the main be encouraged.

Phrenotropic drugs again have further accelerated this trend. On the one hand, since more patients are available and ready for certain types of rehabilitation activities, the need has arisen to keep a great many patients busy in some manner so that they would not be left on the wards to slumber. This has forced the hospital to find suitable, albeit less specific, activities for the many, rather than concentrate on meaningful activities for the few.

One consequence is the revitalization of industrial therapy programs, which have always been popular with improved patients. Another development in our own hospital was with the creation of an entirely new project called the Community Work Shop; patients are taken to various places of employment in the community and receive regular wages for their efforts. This,

as well as a "member employee" program, represent valuable transitional phases of vocational rehabilitation and as such should be further explored.

On the other hand, we have found that as patients show even moderate improvement they become better organized and more reality-oriented, and they express the desire to find activities outside the hospital. Thus, many of our patients have been accustomed to spending prolonged weekends at home. In a sense we have become a mid-week hospital. Incidentally, these home visits may be utilized by the patient to find employment and often lead to trial visit or early discharge.

All these developments have compelled the psychiatrist to speed up and simplify administrative procedures. Often he is forced to make decisions without being able to involve the team. In fact, the patient is often ready to (or should) go home before the team can meet to formulate long-range plans.

#### THE HOSPITAL CLIMATE TODAY

In studying our newly admitted patients we have found that they usually come to the hospital because of the sudden appearance of a psychiatric crisis or emergency. The crisis may arise from various sources, some of them within the patient, others within the environment. After resolution of the crisis, patients are usually returned to their previous environment even though treatment for their mental illness may still be necessary.

The chief contribution of the drugs has been to speed up the resolution of the crisis. One result of this has been the gradual disappearance of rigid differentiation of hospital wards between "acute," chronic, convalescent, etc., and patients need not necessarily reside on different wards during various phases of their illness. Now, on any

given ward one might find patients in various stages of regression or improvement. The so-called "closed wards" have practically disappeared, and privileges, passes and discharges are being granted from any ward in the hospital.

The trend toward using the hospital chiefly as an emergency station during a psychiatric crisis can be further demonstrated by the tremendous increase in patient turnover since the use of the drugs. Bedford, for instance, a 1,750-bed hospital, had a patient turnover of 470 in 1952 compared to 992 in 1957. Patients are now easily admitted to the hospital and just as readily discharged. This creates a constantly fluctuating population which, as a whole, has less investment in the hospital as a community than when the population was more static in nature.

This situation has profoundly influenced the hospital climate. It was not long ago that we thought of the hospital as a "community." This apparently useful concept, especially in the care of long-term patients, viewed the hospital as a miniature replica of the outside community. It was felt that such a model would aid the patient in becoming re-educated to assume eventual real community responsibilities. If on the other hand he failed to achieve extra-hospital status, he was in a sense provided with a ready-made substitute community which he could accept and which would be accepting of him. Only too frequently the patient from the beginning preferred to make the second choice, creating an added difficulty in rehabilitation efforts.

Thus, it is felt that one of the major contributions of the drugs has been to reach and influence the patient before he could make the second choice of accepting the hospital as a substitute community and thereby destroy the roots, however tenuous, which he has on the outside.

It is obvious that with the patient becoming less immersed in the hospital, the culture, function and need for the hospital to be a substitute community has been profoundly altered.

## OUTLOOK

The extensive use of phrenotropic drugs has brought psychiatric hospital concepts and practices into new focus.

The hospital has become, in the main, a place where a patient can receive short-term emergency treatment for a psychiatric crisis. The drugs have helped to speed the resolution of the crisis and the patient is ready to profit sooner from out-patient therapy for the underlying mental illness.

This effectively relates the mental hospital to other community resources. Thus, as the hospital loses its former isolation the patient continues contact with the family and the community. In fact, the family, as well as the employer, have come to look upon a mental disturbance for which hospitalization becomes necessary as nothing more than an episodic occurrence during a person's life.

Within the hospital we note the emergence of new and clearer definitions of the roles of key personnel in the total treatment

program, with a return to primary responsibility for psychiatric care to the physician and nurse. Furthermore, a clearer picture of what the hospital can and should attempt in the way of patient rehabilitation has developed.

From the patient's point of view, the mental hospital has become more acceptable and less frightening. Above all, there has arisen some opportunity to provide a measure of actual individualized care to patients in a large mental hospital.

Finally, it has become apparent that, despite present limitations of drug therapy, as far as eventual cure of mental illness is concerned the drugs significantly reduce, or may even prevent, the traditional chronicity of psychotic illness.

Present needs arising out of intensive use of drug therapy are:

- For the hospital to modify its organization and structure so as to avail itself fully of the opportunity to exploit the patient's accelerated recuperative momentum induced by phrenotropic drugs.
- For the hospital and the community to cooperate in devising adequate and meaningful follow-up facilities, continuing psychiatric and rehabilitative services for the patients in the community.



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STEVE PRATT  
GUY SCOTT  
JOEL LAND  
GORDON GARDINER  
KEITH DIRKS

# Evaluation of a mental health week program

## Part 2

### SELECTED GROUP FOLLOW-UP: CLERGYMEN

Throughout the country, state mental hospitals have each year become increasingly involved in conducting Mental Health Week programs designed to enhance public understanding of this nation's #1 health problem.

Realizing the tremendous expenditure of the hospital staff's time and energy—literally more than 1,000 man-hours for professional personnel alone—being devoted to this annual project, the administration de-

cided to take stock. Therefore, an exploratory evaluation was completed in which the value, structuring and effectiveness were assessed for such a Mental Health Week program<sup>1</sup> as it was conducted at a representative (1,500-bed) midwestern state mental hospital. That investigation evaluated the effects of the program upon those participating *at the time of the program*. As important as such "at-the-time" attitude changes are in assessing effectiveness, it is equally essential to evaluate the longer term effects of participation and the resultant potential of the participants for influencing others through their subsequent activities.

The present study is the first of two separate investigations which make this type of follow-up evaluation of post-participation effects with selected groups chosen as having a particularly significant potential for secondary or "radiated" influence upon others in their community. Because of their unique position in the community,

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The co-authors of this paper are all on the staff of Larned State Hospital in Kansas. Their study—the first part was published in the April 1958 number of *MENTAL HYGIENE*—was one project of an interrelated group research program conducted by the hospital's department of clinical psychology.

<sup>1</sup> Sommer, Dirks, Gardiner, Hinkle, Khanna, McDonald and Pratt, "Evaluation of a Mental Health Week Program," *Mental Hygiene*, 42(April 1958), 195-210.

clergymen were chosen for this study. County officials and social workers were selected for the other follow-up investigation as they likewise play unique roles linking hospital and community. Such assessments should add a further dimension to the evaluation of the effectiveness of a Mental Health Week program.

## PROCEDURE

A multi-type 36-item questionnaire was constructed and sent, four months following the Mental Health Week program, to the 71 clergymen who had specifically registered as such (that is, part-time and/or lay "preachers," etc., were not included) out of the 134 persons who registered their attendance during the Mental Health Week Clergymen's Day program at the hospital. Items of the questionnaire were presented in various forms to facilitate response and expression (for example, "yes-no-don't know," "fill-in," "open-end," "report frequency and/or type," "give examples," etc.). A tracer was sent to those few who did not respond immediately. The questionnaire was completed and returned by 58 clergymen (82%).

Specifically, this follow-up was designed to investigate such questions as these:

- As assessed after a considerable period, had the program been effective in increasing interest in mental health, forming constructive attitudes toward emotional illness, heightening awareness and concern regarding problems in these areas?
- In what ways, if any, had participants transmitted new knowledge and awareness to colleagues, parishioners and community, subsequent to the program?
- Subsequent to and ostensibly as a result of participation, in what ways, if any, had these clergymen instigated or participated

in overt activities relevant to mental health (for example, counseling, referrals, incorporating material in discussions or sermons, etc.)?

- What, if any, activities of this type do they contemplate for the future?

Responses from the completed questionnaires were analyzed and evaluated to find answers to these and similar questions. In brief, what were the continuing effects of their having participated in the Mental Health Week program as perceived and expressed by the clergymen themselves? Did these results, as reported, involve communication and activities which would indicate the spread or "radiation" of such effects to others in their community?

## ATTITUDE CHANGE

It is evident from the original evaluation<sup>1</sup> that a large proportion of those participating in the Mental Health Week program, as reported by them *on the day they attended*, felt at that time that the experience had increased their interest and constructively changed their attitude toward the problems of mental illness. The salient question was, would they still perceive themselves as having undergone or undergoing this positive change in attitude long after the program was passed? Educators are only too painfully aware of the short-lived effects of most well-intentioned attempts to influence public opinion on matters of personal and social concern, particularly in those areas where myth, stereotype and prejudice prevail.

In Table I we see to what extent the clergymen, reporting four months subsequent to Mental Health Week participation, still perceived and presented themselves as having had their attitude toward the problems of mental illness constructively changed.

TABLE 1

*Attitude change*

RESPONSE	YES	NO	DON'T KNOW OR OMITTED
Reported change of attitude	45	8	5
Specified change of attitude * toward:			
Treatment of mental illness	21		
Problems of mental illness	28		
The state mental hospital	3		

\* Some clergymen wrote in more than one example.

Forty-five of the respondents (78%) directly reported such changes. Another 10% stated that while they could not ascribe their favorable attitudes to the Mental Health Week program *per se* they were aware of the problems and expressed sympathetic interest toward patient treatment, the institution, problems of mental health, etc. Examples written in by the clergymen indicate that the two major areas of change involved attitudes and beliefs concerning mental illness (54%) on the one hand and treatment procedures and prognoses (40%) on the other. Only three volunteered examples specifically mentioning change in attitude toward the hospital as such. It could be assumed that in a sense changes in attitude toward the hospital *per se* were absorbed into the areas of mental illness and treatment.

## INFORMATION AND UNDERSTANDING GAINED

Here again, it had been found in the original Mental Health Week study<sup>1</sup> that at the time of attendance participation was perceived as a learning experience.

It can be seen from Table 2 that 51 of the responding clergymen (88%) still perceive themselves, after this considerable passage of time, as having increased their understanding and knowledge of mental health and related activities. Examples given by the respondents reflect the variety and specify the areas of increased knowledge. Nineteen (33%) now credited Mental Health Week participation with a significant increase in their sensitivity to personality problems and awareness of the emotional difficulties or disorders of their parishioners. Thirteen (22%) indicated furthermore that

TABLE 2

*Information and understanding gained*

RESPONSE	YES	NO	DON'T KNOW OR OMITTED
Obtained new knowledge or understanding	51	1	6
Specified area of increase:			
Awareness of personality disorders	19		
Ability to "deal" with emotional problems	13		
Understanding referral procedures	24		
Knowledge of treatment	21		



they now felt better equipped to "evaluate" or "handle" (what to do and what not to do) emotional disorders and/or mental illness. Twenty-four (41%) specifically listed increased know-how concerning actual referral procedures or facilities which could be of considerable practical use when situations arose in which parishioners and their relatives would require such knowledge. This might realistically include very real emergencies (psychotic homicidal outbreaks, suicide attempts, etc.). Finally, 21 ministers (36%) gave examples illustrating their increased understanding of the kinds of psychiatric procedures and/or facilities used in the treatment of mental illness.

#### ACTIVITIES INITIATED

In adding dimensions to the original "at-the-time-of-the-program" Mental Health Week evaluation,<sup>1</sup> findings of the follow-up presented up to this point have in essence been restricted to the fact that clergymen after four months still perceive themselves as having changed attitudes and increased knowledge regarding mental illness. However, the cogent question remains unanswered—what have they *done*, as a result of their Mental Health Week experience, that has increased their own potential or activity with regard to mental health, particularly in influencing, involving or activating others? In short, what have they done that would "radiate" the effects of their experience to others in their profes-

sion and community? The import here is indicated not only by their educative role in the community but also by the conservative estimate made by the hospital chaplain<sup>1</sup> that the number of parishioners directly represented by 100 of these clergymen is approximately 25,000.

Responses to this key question are presented in Tables 3a, 3b and 3c. They reveal that the clergymen, ostensibly as a result of Mental Health Week participation, had initiated or participated in a very wide range of such potentially "radiating" activities, from simple "communication" (mentioning attendance) to the organization of mental health study groups. For instance, from Table 3a it may be seen that all but two of the clergymen reported that they had mentioned their attendance to others. Fifty-two (90%) indicated they felt this experience to be helpful by recommending to others that they attend future Mental Health Week programs sponsored by the hospital. Forty-two (72%) indicated that they had made it a point to discuss their experiences in the program with others—as one put it, "to pass on the information gained to other ministers and Christian workers who did not attend the session."

Table 3b relates to communication, proposals and activities reported by the clergymen which directly involve other members of the ministry. Thirty-two (55%) stated that since attending the program they had proposed specific mental health activities to

TABLE 3A

*Activities initiated: referring to Mental Health Week program*

RESPONSE	YES	NO	DON'T KNOW OR OMITTED
Mentioned their attendance	56	2	0
Recommended future attendance	52	5	1
Discussed Mental Health Week experiences with others	42	2	14

TABLE 3B

*Activities initiated: involving other clergymen*

RESPONSE	YES	NO	DON'T KNOW OR OMITTED
Proposed mental health activities	32	6	20
Discussed Mental Health Week experience:			
At Ministerial Alliance	27	23	4
With same-faith clergy	16		
With other-faith clergy	21		

other clergymen. In connection with their participation in Ministerial Alliance conferences the following involvement of Mental Health Week experiences was reported. Half of the clergymen had discussed their Mental Health Week experience at these meetings. Such discussions included informal reference to the program and to their attendance, formal announcements of their participation in the program, detailed discussion of these experiences, urging others to attend future Mental Health Week programs sponsored by the state mental hospital, and presentation of definite plans for Mental Health Week activity at the alliance meetings. Sixteen ministers specified that discussion of their experience at the alliance

meeting was with clergymen of their own church; 21 (36%) talked with members of religious denominations other than their own, indicating that communication or "radiation" was not restricted to members of the same faith, but was interdenominational. Such communications among clergymen regarding Mental Health Week experiences were reported as having involved both supervisors and supervisees.

The potential of secondary or "radiated" effects generated through the clergymen's participation in such a Mental Health Week program is perhaps most directly reflected by reports and examples of their overt application of knowledge gained through that experience. It can be seen

TABLE 3C

*Activities initiated: applications of knowledge gained*

RESPONSE	YES	NO	DON'T KNOW OR OMITTED
Applied knowledge gained	54	4	0
Specified application:			
Visits with parishioners	38		
Talking to other individuals	29		
At informal gatherings	18		
Speaking to groups (sermons, etc.)	43		
In teaching (general)	14		
In study groups	14		
Personal counseling	30		
Referrals for psychiatric help	6		

from Table 3c that 54 of the responding clergymen (93%) reported that they had applied knowledge gained through the program, and it is evident that such application and activities exploit the clergymen's role, both professionally as a minister and as a civic member of the community. Thirty-eight (65%) had applied this experience in visits to or with their parishioners; while this was generally with adults, there were also instances involving church youth. On the other hand, half of the ministers specified they had found use for the information gained in talking with other individuals outside of their professional contacts and outside their congregation. Here again, as previously in relation to other-faith *vs.* same-faith communication between clergymen, we see that the "radiated" effects are also interdenominational.

More than one-fourth of the clergymen indicated that they had taken the opportunity of introducing or applying aspects of their Mental Health Week experience in connection with informal gatherings. Three-fourths reported the use of such material in speaking to various types of groups. More than half of these had used the material in sermons. This varied from simply mentioning the topic to developing complete sermons around the mental health theme. An example of extensive use was the organization of a series of sermons on the general topic, "Our Attitudes and Our Health." Seventeen ministers reported incorporation of their newly-gained knowledge into talks to church groups such as women's organizations, guilds, circles and church youth groups, while others utilized the experience in talking to adult groups—for example, civic clubs—outside their church. Some also used it in giving talks to groups composed of ministers (outside the Ministerial Alliance).

Application of the experience directly

through teaching was reported by 14 clergymen (24%). Examples given included parochial school classes, regular Sunday School classes, and adult Bible study classes. Some indicated the content—for example, contrasting present-day attitudes toward mental illness and the care of the mentally ill with that depicted in the Bible.

Another 14 stated that they had spread information on mental health specifically through study groups. These included a professional ministerial study group, youth and adult study groups both within and outside the church; the latter included a community organization study group and a study group of professionals interested in a sectarian mental hospital.

Most, if not all, clergymen participate in one form or another (individual, family or group) in personal counseling with parishioners or others who consider the minister to be a mature and responsible person in the community. Thirty responding clergymen (52%) stated that they had used information gained through their Mental Health Week experience in such personal counseling. While this was primarily with adults, application in counseling youth was also reported. That those who had participated in the program at the hospital now found themselves better prepared to understand and deal with some of the more acute problems which arise in connection with mental illness was reflected by the fact that one out of nine clergymen reported having had occasion to use, subsequent to Mental Health Week, information in referring parishioners for psychiatric evaluation, out-patient treatment or hospitalization.

It is of interest to know how soon after their Mental Health Week participation the clergymen first took occasion to utilize the experience gained in applying through such activities as those discussed



TABLE 4

*Time after Mental Health Week within which experience was first utilized*

1ST MONTH	2ND MONTH	3RD-4TH MONTH	FUTURE	DON'T KNOW OR OMITTED
29	9	4	6	10

above. Table 4 presents the time after Mental Health Week within which they reported having first put such experience to use. Some of the activities were apparently initiated almost immediately after attendance at the program, and the majority were begun during the first month; only a few were started after several months had passed.

Altogether, nearly three-fourths of the group found means of first utilizing their experience within the 4-month period subsequent to the program, prior to the date of reporting. Exactly half of all responding clergymen had made use of the experience within a month after Mental Health Week. Nine (16%) stated that they first utilized their experience during the second month, 4 within the third and fourth months, while 6 who had not yet initiated activities as a result of the experience reported that they planned to do so in the future.

#### PLANS FOR FUTURE APPLICATION

In evaluating potential for "radiated" effects of Mental Health Week participation, the clergymen's plans for future endeavors in this area must be considered in addition to activities already initiated or accomplished. Such proposals may relate to new activities to be undertaken as well as to plans to continue or extend current application or utilization of material gained through the Mental Health Week program. In Table 5 it can be seen that 55 of the clergymen (95%) outlined definite plans for future mental health-oriented activities.

Expressed plans were varied and overlapped, but for convenience may be presented in five groups.

More than three-fourths of the responding clergymen indicated definite plans to attend the next Mental Health Week program sponsored by the state hospital. Each of the three who stated that they did not plan to do so had moved out of the state. The remainder indicated that they had not yet decided or that there was a possibility that they might be transferred to churches outside the area served by the hospital.

Seven clergymen wrote that they planned to participate in other types of mental health programs—for example, "I also intend to encourage such things as the Health Workshop which has been a county-wide program in my county" and "to bring along all newly-placed ministers in my area." Plans to actively seek further information about mental illness or mental hygiene were presented by eight others. Some of these reported plans to "take advantage of all opportunity to inform myself better," "to work closely with the state hospital chaplain in order to advance understanding of mental health problems," and "to do more personal study in the field of emotional and mental health and participate in the Mental Health Week program again next year."

Seventeen clergymen stated they intended to convey to others the information they had gained through attending the Mental Health Week program. Of these, more than half stated they intended to communicate the information to their parishioners and

TABLE 5

*Plans for future application*

RESPONSE	YES	NO	DON'T KNOW OR OMITTED
Reported having made plans for future	55	1	2
Specified plans:			
Participate in next state hospital Mental Health Week program	45		
Participate in other mental health programs	7		
Seek additional mental health information	8		
Convey mental health information to others	17		
Use Mental Health Week experience in counseling	14		

about a third planned to discuss it with other clergymen. One minister who indicated that his position with his church restricted non-sectarian activities nevertheless stated his intent to urge other ministers of his district to attend future Mental Health Week programs.

About a fourth of the clergymen wrote in specific plans to utilize their Mental Health Week experience in pastoral counseling. It will be recalled that more than half of the clergymen had reported having already made this application.

## DISCUSSION

The findings of this follow-up study should be considered in relation to the following rather global factors: Mental illness and its treatment constitute the single most important health problem facing the country. Perhaps more than for any other illness, effective treatment must involve and take into account patient, family and community attitudes. And these attitudes toward mental illness, treatment and major treatment facilities (that is, state mental hospitals) are laden with pessimism, negativistic stereotypes, myths and prejudices.

Over the last ten years increasing numbers of institutions, including state mental

hospitals throughout the country have been conducting annual Mental Health Week programs designed to enhance public knowledge in this area. In view of the overwhelming need for these educative activities but also considering the "exorbitant" effort required on the part of the professional staff to conduct these programs,<sup>1</sup> assessment of effectiveness is a matter of considerable significance both in the number of persons reached through direct attendance and in communicating or "radiating" the effects of their participation to others. There were close to 3,000 visitors at the Mental Health Week program evaluated in the original and follow-up studies. It is estimated that a total of some 15,000 persons have attended the several previous Mental Health Week programs sponsored by this state hospital. Projection of these figures for the next 10 years would mean an additional number that would make an over-all total close to 50,000. Certainly the pebble-in-the-brook model could be applied here to the "radiated" effects as reported in the findings of the present follow-up study. In the clergymen group *per se* it is relevant in considering the findings that each 100 clergymen participating in such a program represents approximately 25,000 parishioners.

To return, then, to some of the implications of the immediate findings. It was found at the time of the original study that on the actual day of attendance the clergymen as a group (95%) reported that participation had increased their interest in problems relating to mental illness, and that while visiting the hospital they were pleasantly surprised, sympathetic and wanted to do something constructive. Thus, the original study indicated that attitudes were changed in a positive direction, interest increased and motivation to do something generated. However much this was to the good, only a follow-up study could reveal whether these attitudes were sustained, the interest continued and the elicited motivation in fact put into effect through overt activities.

Likewise, only by conducting a follow-up investigation could one get at the "radiation" effects or potential of subsequently initiated activities, as these represented communication with others and the involvement of others in mental health-oriented endeavors.

It was seen that 78% of these clergymen specifically reported changes in attitude attributed by them to the experience of participation in the Mental Health Week program. It could be reasonably assumed that such attitude changes served as prerequisites to and provided the springboard for plans and activities subsequently initiated. Likewise, these attitude changes *per se* dovetail with "information and understanding gained" (reported by 88%) in contributing toward the resultant appropriateness and effectiveness of the overt activities initiated. Motivation and action if resulting from uninformed or misguided enthusiasm could have meant less than desirable "radiated" effects, to say the least.

The literature is replete with studies exposing the prejudicial defeatism charac-

terizing attitudes toward mental illness currently prevalent in our culture. Independent research projects<sup>2</sup> conducted at this hospital—Larned State—will delineate and assess the extent of this negativism particularly as directed toward the state mental hospital, which constitutes the major and usually the sole available treatment facility. Clergymen, however, are in a unique position in the community not only to effect public attitude changes but to relate to parishioners constructively through counseling, giving realistic information, and assisting in the making of appropriate referrals. How close they are to such problems was revealed in the original study—without exception every clergyman reported that he had been in personal contact with someone suffering from mental illness. His role-relation at such times with both the patient and family can obviously be crucial. Patient and family characteristically perceive hospitalization in a mental hospital as catastrophic: the snakepit, the end-of-the-road stereotype.

Equally crucial, if not more so, considering popular attitudes towards those who have been "crazy" or in an "insane asylum," is the acceptance received by such patients from family and community upon their discharge. The discharge rate nationally, and particularly in Kansas, has improved dramatically but its ubiquitous shadow, the shocking readmission rate, remains relatively unpublicized. The clergymen's sensitivity to the educative needs of the public concerning mental illness, its treatment and the mental hospital, was unexpectedly (as not directly solicited) revealed in the origi-

<sup>2</sup> S. Pratt, D. Giannitrapani, P. Khanna, "Attitudes of the Town-Community Toward the Psychiatric Hospital-Community." Part I was presented at the 1958 convention of the American Psychological Association; parts 2, 3 and 4 are in preparation.



nal study. Under "suggestions for improving the hospital," clergymen singled out hospital publicity and educational programs for mental health as the most urgent needs—whereas other groups stressed such items as plant improvements and increase in staff and patient recreational activities as the most urgent needs. Actually, their stress on this point was sufficient to intelligently restructure the intent of the question posed. Was it, we asked ourselves, naively restrictive?

The crux of the follow-up is to be found in relation to activities initiated (how many clergymen have done what sorts of things) and the secondary effects set in motion by these activities.

Most simply and specifically put, we now know that communication regarding the Mental Health Week experience does not cease as of 5:00 the day of attendance at the program. Most of the clergymen proceed to actively discuss these experiences, with clergymen of the same and other faiths as well as with parishioners and non-parishioners.

These discussions in turn extend into activities which involve changing the attitudes of others toward mental illness; disseminating factual information gained, through sermons, visits, study groups, teaching; proposing and organizing mental health oriented activities and programs; and counseling persons suffering from mental illness as well as giving support and guidance to their families at such times of need.

The original study demonstrated that striking changes in perception of a mental

hospital can occur as a result of participation in even a 1-day program: virtually without exception visitors who had expected to see patients as "peculiar-acting" persons and the hospital "like a prison" reported reversals of these expectancies. Since the results demonstrate that clergymen subsequently act to sustain and extend these attitude changes, they are in a unique position to serve as a continuing link between the town and the mental hospital. Nationally, the recent rapid growth of interest at theological seminaries and universities in clinical training and pastoral counseling<sup>3</sup> indicates an extension of concern for spiritual problems to psychological problems and emotional health. The present study underlines the potential of clergymen for complementing and supplementing the hospital's treatment program. Their contribution in the community certainly can immediately affect both inpatient and outpatient services of the hospital. Joint conferences should be arranged periodically between hospital personnel, family physicians and clergymen of each community served by the hospital.

The original study and the follow-up revealed that clergymen as a group are eager to gain more information about mental health and highly motivated to disseminate this knowledge in their community. Further ways in which this involvement can be channeled constructively need to be explored. It was found that most of the clergymen who participated in the Mental Health Week program have since recommended future attendance to others and also plan to attend the following years' program themselves. This re-participation suggests that future programs must provide for variation and for parallel advanced activities such as discussions and panels for "repeaters." However, the central suggestion stemming from this follow-up, in terms

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<sup>3</sup> "Clinical Pastoral Training," Council for Clinical Training, 2 E. 103 St., New York 29. Presents training standards and lists 45 accredited training centers in mental and general hospitals, penal and correctional institutions, and specialized hospitals.

of future planning, points to a specific need—namely, that the clergyman's potential mental health role in communication, changing attitudes, initiating activities, influencing and involving others should be consciously considered the primary objective in structuring the clergymen's Mental Health Week participation. This would place a completely new emphasis upon their participation, "radiation" potential, and community-with-hospital role.

In relation to serving as a link between hospital and community, follow-up findings suggest the feasibility of furthering the minister's function as an agent having entree to community circles, a person who can move between two relatively closed social systems. In this role the clergyman can make not just Clergymen's Day of Mental Health Week but every day a time for furthering the mental health movement, for extending the hospital's mental health program throughout the year. As just one example, a hospital-produced movie depicting a patient's progress from admission through treatment to discharge could be presented, not just as part of the annual Mental Health Week program, but with accompanying discussion to church and community groups throughout the year. Analogous extensions of the hospital's Mental Health Week programing (for example, inter-group meetings), materials (for example, an original hospital poster series) and events (for example, panel discussions) could be sponsored by clergymen in their communities as continuing projects. The hospital in turn could arrange additional programs involving clergymen. This could include a periodic series of training seminars, a regular course and practicum in pastoral counseling, work with patients on a planned basis, cooperation and development of the volunteer program, etc.

## SUMMARY

Both local and national need, as well as the "exorbitant" cost in staff time and energy involved, argue the necessity of evaluating the effectiveness of Mental Health Week programs sponsored annually by state mental Hospitals. This is one of two follow-up studies designed to add a post-participation dimension to the original "at-the-time-of-participation" assessment. In short, to try to get at the longer term effects of participation upon those who attended and the resultant potential of these participants for influencing others through their subsequent activities.

Clergymen were selected for this study because of their unique position and potential for constructively influencing others and their role linking town and psychiatric hospital communities.

A multi-type, 36-item questionnaire was constructed and sent four months after attendance to the 71 registered clergymen who had participated in Clergymen's Day of the 4-day Mental Health Week program sponsored by a large (1,500 bed) midwestern state mental hospital.

Their responses—82% of the clergymen completed the questionnaire—were tabulated and the findings discussed in terms of Mental Health Week program evaluation and implications regarding the potential role of clergymen in community-patient-hospital relationships. Some of the more significant results follow:

1. Four months subsequent to attendance, 78% of the clergymen specifically reported constructive changes in attitude regarding mental illness and its treatment, attributed by them to their having participated in the Mental Health Week program.
2. After this considerable passage of time, 88% still perceived or presented themselves

as having increased their understanding and knowledge of mental health and related activities: awareness of personality disorders, appropriate ways of handling emotional problems, referral procedures, hospital treatment facilities, etc.

Essentially, these findings indicate that interest, understanding and knowledge gained were sustained. The crux of the follow-up, however, is in the pudding—what they report having done.

3. Most of the clergymen discussed their Mental Health Week experiences with clergymen of the same or another faith, and with parishioners and others in their communities, and then proceeded (93%) to initiate specific mental health oriented activities. Such reported activities involved changing the attitudes of others toward mental illness; disseminating factual information gained by communicating it through sermons, visits, study groups, and teaching; counseling with parishioners and with pa-

tients and their families; assisting with referrals; proposing and organizing programs for mental health.

4. The fact that 95% of the clergymen outlined definite plans for future application of knowledge gained emphasizes the continuing nature of their motivation. Their plans extended the scope of activities already initiated.

The implications of the findings were discussed in relation to the "radiation" potential of participating clergymen for constructively influencing others regarding mental health, while stressing the need to structure future Mental Health Week programs in a way that would effect optimal exploitation of both this potential and of the clergymen's role linking hospital, patient and community.

#### ACKNOWLEDGEMENT

The authors wish to express their appreciation to the clergymen who participated in this research.



# Book Reviews

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## DIRECTORY FOR EXCEPTIONAL CHILDREN; EDUCATIONAL AND TRAINING FACILITIES

*Boston, Porter Sargent, 1958. 3rd ed. 320 pp.*

Over three and one-half million children in our country require special kinds of education. Locating the right facility for any one of these is to say the least, quite a chore. This third edition of the directory describes schools, homes, clinics, hospitals and services for the socially maladjusted, mentally retarded, emotionally and physically handicapped and many more.

It is advisable to keep in mind that schools at great distances are available for care and treatment purposes because of modern means of transportation. This directory therefore takes on added significance since it is quite comprehensive in its nationwide coverage. There are well over 2,000 names and addresses of special facilities for the exceptional individual. Professional workers, schools, libraries, parents and patients themselves will find this edition as handy as the telephone directory.—ARTHUR LERNER, Los Angeles City College.

## HOSPITALIZING THE MENTALLY ILL: EMERGENCY AND TEMPORARY COMMITMENTS

Reprinted from *Current Trends in State Legislation, 1955-56*

By Hugh A. Ross

*Ann Arbor, University of Michigan Legislative Research Center, 1958. 96 pp.*

In this extensive article the author presents the results of a study of state legislation on emergency and temporary commitments to

mental hospitals. He points out that in general the laws relating to admission to mental hospitals are "cumbersome and archaic"; his aim in the present study is to enable legislative draftsmen to improve on the present procedures. Of this aim all who are interested in the welfare of the mentally ill can heartily approve.

Professor Ross reminds us that there are at least six separate types of admission procedures: voluntary (treated by him in an earlier publication); admission by guardian; nonprotested admission; emergency commitment; temporary commitment; and formal commitment.

As to the second, the state of the law is nebulous and should be clarified by legislation.

Nonprotested admission lies between voluntary and compulsory commitment. At least 9 states have this provision, and it is incorporated in the Draft Act proposed by the United States Public Health Service. The method calls for at least acquiescence on the part of the patient, but avoids the formality of a court commitment. Another advantage is that it encourages early hospitalization.

In emergencies, some method of prompt hospitalization is necessary. Such a right existed under common law, and does still exist in some of the 40 states which have made statutory provision. This is an area in which careful draftsmanship is desirable, for the protection of all concerned.

In less urgent cases, temporary commitment is desirable for observation, and at least 10 states have provided for it. The term of commitment is limited, and the legal formalities should be less rigorous than for ordinary commitment.

One of the confusing and confused questions is that of the effect of commitment (of

any sort) upon the patient's legal capacity. To say that the law is generally unclear on this point is to put it mildly. Too many of the courts seem to reason that insanity means commitment and insanity means incompetency; *ergo*, commitment automatically results in incompetency. Such reasoning works a genuine hardship on many patients; the Draft Act attempts to clarify the situation. To make commitment the equivalent of incompetency operates against early hospitalization and impedes rehabilitation.

Professor Ross approves the Draft Act in general but offers some suggestions for its improvement. Certainly the states would do well to consider carefully the enactment of this proposed legislation as more humane than many of the statutes which now exist. He has given us a scholarly (379 footnotes) and progressive presentation of the facts and the desiderata in a field which contains too much still of formalism and disregard of the welfare of the mentally ill.—WINFRED OVERHOLSER, M.D., St. Elizabeths Hospital, Washington, D. C.

## ETHICS, THE PRINCIPLES OF WISE CHOICE

By Charles A. Baylis

New York, Henry Holt & Company, 1958. 373 pp.

In these days of vacillating moral values, it is refreshing to remind ourselves that there is such a field as ethics. Man for himself, a phrase of noble but also insidious implications, releases a kind of moral freedom which can easily abandon standards. The author in a systematic manner discusses ethics as the search for principles of wise choice and reviews the classical arguments. The ethics of duty, personal whim as the

basis of choice, the ethics of value, and the problem of responsibility are some of the topics presented.

Today, when religionists and moralists are being compelled to reexamine their cherished assumptions in the light of new insights from psychiatry, psychology, cultural anthropology and sociology, there are bound to be radical conflicts between the older schools of thought and the modern psychological orientation. Our developing knowledge of the unconscious—particularly as it concerns motivation, free will, responsibility, determinism and the need to evaluate our value systems in the light of these new knowledges—greatly modifies many of the traditional approaches to such problems as ethics, morals and religion. The author does not seem to be sufficiently aware of depth psychology, and the problem of the unconscious is almost totally ignored.

We need to relate moral value systems to mental health, but the book makes little mention of this. When the author's discussions relate to psychodynamics, he is most unsatisfactory. His theory is liberal—that is to say, he permits us wide scope in relating duty to religious obligations—and he does us a real service by asking the right questions about behavior. But his answers are unsatisfactory. His ethical theory seems to be that happiness is good, and unhappiness is bad. He is extremely wordy and repetitious in his desire to state the issues, and the reader often gets lost in rather superficial illustrations. His discussions of absolute self reveal a misunderstanding of that term as used by behavioral scientists.

Yet he raises the questions we should want to think about. The answers will be difficult to find and no doubt could never be universally accepted. But can we find the right answers to a system of values when there are so many conflicts among religious and cultural groups? The confusion is

compounded further by the big problems of determinism and unconscious motivation.

The book makes interesting reading for mental health workers who may have forgotten that ethics and morals should be an essential part of personality maturation. The religionist will not be satisfied by the conclusions of the author, but the author compels us to do some serious thinking about some very fundamental things.—  
GEORGE C. ANDERSON, Academy of Religion and Mental Health.

#### CASEWORK PAPERS 1957 FROM THE NATIONAL CONFERENCE ON SOCIAL WELFARE

*New York, Family Service Association of America, 1957. 158 pp.*

This is a volume that should be read by every social worker—not just the caseworker. The aim of the editorial committee was to cover as wide a range of subjects as possible. Accordingly, the 12 excellent papers selected are so diversified that it is impossible to do them justice in this brief review.

In 4 papers specific casework services are discussed. The complexity of the caseworker's role with the unmarried mother is sensitively revealed by G. Leyendecker. A strong and logical plea is made in 3 papers for individual services for the prisoner (by W. Nagel), the mentally retarded child and his parents (by M. Mednick), and children in public assistance (by E. Minton). Miss Minton includes in her article a good but brief review of the development of federally aided programs.

The reports of 2 intercountry projects in adoption of children are not only timely but also extremely interesting. M. Valk writes of adopted Korean children, L.

Graham of Japanese. Although these reports reaffirm our theories about adoptions, further research by a team including an anthropologist is undoubtedly needed.

A fine delineation of the supervisor's role in meeting the needs of a first year worker—needs differing from a student's—in a family agency is given by R. Reynolds. New and stimulating ideas for the use of specific allied services are spelled out by P. Margolis for the homemaker service and by M. Collins for the volunteer in serving individuals.

After presenting his convincing arguments for a specific approach in all areas of social work, S. Mencher states that learning experiences related to research should be integrated into the basic curriculum. Discriminating references are included here as well as in other papers, but no bibliography is attached. In the reviewer's opinion, such an addition would have been a valuable aid to students and teachers.

Quite appropriately, the leading article is a brilliant discussion by M. Pumphrey of Mary Richmond's concepts. Following this is M. Friend's "Family Process" in which he discusses some of the same concepts. Can it be that Mary Richmond's fears have been realized? Has the caseworker become too specialized, too involved with deeper insights and lost his identity thereby?

This collection of first-rate papers underlines "that social work has a body of knowledge and theory distinctly its own.—MIRA TALBOT, New York City.

#### ENVY AND GRATITUDE

By Melanie Klein

*New York, Basic Books, 1957. 101 pp.*

Melanie Klein is one of the pioneers in psychoanalysis, especially child analysis. Her work has not received the attention in



this country that it deserves, largely because her theoretical work, her metapsychology and techniques are not in accord with the clinical material and findings. Rich, imaginative, thought-provoking, stimulating—and difficult—describe Melanie Klein's writings.

Throughout her work she has emphasized the fundamental importance to the infant of his first object relations—mother and mother's breast. If this introjection takes root in the ego with relative security, the basis is laid for later satisfactory development.

This book deals with a particular aspect of earliest relations and internalization processes rooted in orality—envy. "Envy is the angry feeling that another person possesses and enjoys something desirable—the envious impulse being to take it away or to spoil it. Moreover, envy implies the subject's relation to one person only and goes back to the earliest, exclusive relation with the mother."

Melanie Klein attributes much—too much without scientific evidence—to the pre-verbal period of infancy. Pre-verbal emotions and fantasies appear as "memories in feelings" in the transference situation. The first object to be envied is the feeding breast, which possesses everything the infant desires. It is well known from her previous writings that "if envy is excessive, this indicates that paranoid and schizoid features are abnormally strong and that such an infant can be regarded as ill."

A major derivative of the capacity for love is the feeling of gratitude which is rooted in the emotions and attitudes that arise in the earliest stage of infancy. "It is essential in building up the relation to the good object and underlies the appreciation of goodness in others and in oneself. Gratitude is closely bound up with generosity."

It is not possible in a review to discuss this rich monograph. Her views on early ego, ego-splitting, the onset of guilt, the ramifications of envy, the case illustrations, defenses against envy are clearly presented. Her departures from Freud, and particularly Abraham, are carefully stated.

This is a most interesting, lucidly written book by a great student. No psychoanalyst, no child analyst, should miss reading this work. If other disciplines are sufficiently grounded in psychoanalytic metapsychology, there is no question that they will profit too. One ought to read especially those with whom one disagrees.—JOSEPH D. TEICHER, M.D., Child Guidance Clinic of Los Angeles.

## DISCOVERING OURSELVES

By Edward A. Strecker and  
Kenneth E. Appel

*New York, Macmillan Company, 1958. 3rd ed.  
303 pp.*

This book, revised in a 3rd edition 27 years following its original publication, discusses the fundamentals that must be considered in any attempt to seek some of the answers to the psychological aspects of living. Such are the intimate relationship of the body-mind, the elementary concepts of psychology, sensation, perception, thinking, emotion, etc.,—all channeled to the ultimate objective of action. From this the book progresses through an explanation of the conscious and unconscious factors in behavior to a discussion of the personality development. This latter is along Freudian concepts, yet the book's general tone does not stress psychoanalytical approaches.

Part 2, charting a course, describes in considerable detail the nature of emotion

and the ramifications of such widespread and basic emotions as anger and fear. Then are taken up fundamental mental mechanisms—rationalization, repression and others. The author also gives a resumé of the clinical conditions in which energy at the emotional level manifests itself in the symptom groupings known as hysteria, neurasthenia and anxiety states. A chapter on the so-called inferiority complex, followed by sublimation, completes the book. An interesting feature is the appendix, with thought-stimulating questions on the various chapters and a series of searching questions aimed at promoting self-analysis.

This reviewer considers the work as excellent—clearly stated and utilizing the maximum of vocabulary known to the educated non-medical reader. Cases are cited but these are briefly given in concise terms. They illustrate without becoming elaborated case studies. In the main it would seem that formulations are presented with vigor and yet without the dogmatism that excludes other notions. In this process there will be implied assumptions that intellectual understanding can do more than it probably can. This is inevitable. When we talk about our mental functioning, it is natural to assume that concepts themselves, as concepts, are capable of carrying much of the load that is always at a non-intellectualistic and non-verbal level. Yet try to think and understand we must, and we cannot do it without words and intellectualistic constructs.

The authors have had experience as clinicians and teachers in Philadelphia, one of the foremost medico-psychiatric centers, over several decades and there they have distilled much of this experience. This reviewer knows of no book for the layman that he considers more sound and forthrightly written.—FORREST N. ANDERSON, M.D., Van Nuys, Calif.

## MARRIAGE COUNSELING: A CASEBOOK

Edited for the American Association of Marriage Counselors by Emily H. Mudd and others

*New York, Association Press, 1958. 488 pp.*

This is a sober and conscientious book which presents 41 case reports of counseling experiences with a wide variety of marital and pre-marital problems. The reports are written by 38 different members of the American Association of Marriage Counselors, but the authorship of each case is not revealed to protect the anonymity of the clients. Most of the authors received their primary training in the behavioral and social sciences—sociology, social work and psychology. Five are physicians—three gynecologists and two psychiatrists (a surprisingly low representation of the latter!).

Some of the general areas covered by the case reports are youthful marriages, dominance and submission in marriage, problems of sexual adjustment, the triangle in marriage, neurotic interaction, premarital counseling, sex problems of engaged couples, problems of mate selection, and cultural differences as they relate to the choice of a marriage partner.

Included also are two relatively brief but thoughtful introductory chapters on marriage in the United States today and the principles, processes and techniques of marriage counseling, and two concluding chapters on marriage counseling today and tomorrow.

The emphasis in the chapter on principles, processes and techniques is that "the marriage counselor deals more often with so-called normal, average people" and that therefore "the marriage counselor who is not a psychiatrist and who has no special training . . . should not indulge in extended

analyses or attempt fundamental personality changes." Moreover, he "must make certain, so far as possible, that he is not dealing with a deep-seated psychotic or neurotic behavior manifestation with which it is beyond his ability to cope" and he must "be prepared . . . where needed . . . to lay the groundwork for a constructive psychiatric referral."

The book should be of interest not only to marriage counselors but to all who come into contact with marital and family problems in the course of their work—social workers, probation officers, psychologists, physicians and others. Even the trained psychiatrist, though he may find most of the material relatively familiar, may discover much in the case material that is stimulating and provocative. It is regrettable that the editors did not see fit to provide an index.—  
JUDD MARMOR, M.D., Beverly Hills, Calif.

### SOCIAL PSYCHOLOGY: AN INTRODUCTION TO THE STUDY OF HUMAN RELATIONS

By S. Stansfeld Sargent and  
Robert C. Williamson

*New York, Ronald Press, 1958. 2nd ed. 649 pp.*

The first edition of this text (1950) was subtitled "An Integrative Interpretation"; the recent one purports to be "An Introduction to the Study of Human Relations" designed for intermediate courses in psychology, sociology, social science survey and human relations courses. The first edition was a solo performance by psychologist Sargent; the second is a joint effort with another psychologist, Professor Williamson.

The new edition is by no means a thorough revision; yet it brings the first

book up to date and adds 4 new chapters: on group dynamics and its applications, ethnics relations and prejudice, social psychology and international relations, and the present and future of social psychology. The last two of the added chapters, however, show little depth in the unprecedented era of the atom.

The authors define social psychology as "the scientific study of persons as members of groups with emphasis on their social or interpersonal relationships." So far, so good. But why limit this expanding field to interpersonal behavior, in the new age of intercultural and intersocietal relationships?

While this textbook comes closer to a genuinely interdisciplinary point of view than most of the three-score texts published during the last fifty years, it nevertheless stops short of a complete synthesis of the behavioral sciences, especially in its failure to relate the pertinent findings of physiology, neurology and psychiatry to a discussion of the development of personality and character.

Nevertheless, the second edition, like the first, has much to commend it as a good source book supporting an undergraduate orientation course in human relations; it is clear, well-written and carefully documented with useful references. Like so many textbook revisions, however, it is longer (by 130 pages), larger, heavier and, of course, costlier than the original.

Experienced teachers of social psychology are still hoping to find a smaller book with a more daring hypothesis, in keeping with the expanding scope and the growing importance of the field. "Men grow," said the late Professor Whitehead, "in an attempt—however unsuccessful—to conceive of the whole of reality at one sweep."—ARTHUR L. BEELEY, University of Utah.



POPULATION IN ITS  
HUMAN ASPECTS

By Harold A. Phelps and  
David Henderson

New York, Appleton-Century-Crofts, 1958. 512 pp.

It is through the light they throw upon the social systems which generate them that population data achieve their own interest. In this book, one of a sociology series, the authors have set out to interpret basic population data in these terms, and to a large measure they have succeeded. Inevitably in a work of wide scope there is some unevenness, and the whole book suffers somewhat from lack of an over-all, coherent, theoretical framework, but the general result is clear, competent and more than ordinarily interesting.

There are 6 main sections. The first is concerned with the number of people in the world through time and across the face of the earth, with emphasis upon the United States. The second part examines the ways in which Americans distribute themselves in city, suburb, town and country—and of course the social processes underlying this distribution—while the third section deals with their racial and ethnic origins. The fourth part examines the stability of the composition of the population—its age, its family patterns, its education, its religion and occupation. The fifth deals with various aspects of physical, psychological and social health. Part 6 is composite and is concerned with predictions of the future as well as with an historical appraisal of the great men of demography. Finally, it deals with the question which has been latent in the book all the time: "What's to be done about the population of the world?"

At this point the authors make explicit the moral and philosophical assumptions

which have been evident through the book, and formulate very clearly the problems of population planning. This is an excellent idea, for in the social sciences, when it is impossible not to evaluate, it is best to make clear the standards of judgment used so that the reader may accept them or reject them as he pleases. In this case they are ethical-humanistic standards and sit well—at least with this reviewer.—ELAINE CUMMING, New York State Department of Mental Hygiene.

THE PSYCHIATRIC HOSPITAL  
AS A SMALL SOCIETY

By William Caudill

Cambridge, Harvard University Press, 1958. 406 pp.

In the past five years you have perhaps read Jones's *The Therapeutic Community*, Stanton and Schwartz's *The Mental Hospital*, the Greenblatt-York-Brown study titled *From Custodial to Therapeutic Patient Care in Mental Hospitals*, Belknap's *Human Problems of a State Mental Hospital* and the Greenblatt-Levinson-Williams symposium on *The Patient and the Mental Hospital*, to say nothing of a long list of journal articles. You might easily conclude that you should not spare time to read still another book about the psychiatric hospital as viewed in social science perspective. This reviewer begs you not to come to that conclusion. Once you begin William Caudill's exceptionally well written and carefully studied volume you will undoubtedly discover that, although it deals with many of the basic problems discussed in the earlier publications, it adds *much* both in conceptualization and in description of research methods. What it adds is of great value to all categories of personnel—clinical psychologists, psychiatric nurses and social workers as well as psychiatrists—who are struggling

with the task of how to make the mental hospital truly a therapeutic community. Moreover, the final chapter, *The Possibility of a Clinical Anthropology*, indicates an evolving role in connection with that task for the anthropologist and by implication for other kinds of social scientists.

The purpose of the book is to explore the social system of one small psychiatric hospital to attempt to discover the meaning of that system both for patients and staff. Emphasis has been placed on three broad areas of life within the institution which Dr. Caudill has designated as therapy, administrative care and human relations; on the status, roles, values and beliefs of the various categories of staff; on the flow of communication throughout the institution; and on the resulting patterns of interpersonal relations and group interaction.

The principal methods used for obtaining data were direct observation and interviewing. Caudill's earlier indirect observations, made through assuming for two months the role of a patient, unquestionably contributed to the direction and depth of these methods. Over 300 hours were spent in observation on the men's locked ward and an equal amount on two open wards. (As a consequence he suggests that residents should spend much more time on wards, and for a limited time should live on them.) For several months he kept detailed notes of what occurred at the semiweekly clinical case conferences and also at the daily staff administrative conference attended by senior psychiatrists, residents, supervisory and staff nurses, the social worker and the occupational therapist. Interviewing was used extensively through a technique of showing pictures of hospital life, which are reproduced in the text, both to patients and personnel individually, with the request that they comment on the content of the pictures.

Caudill's method of presentation of his considerable data is skillful. By permitting the reader to follow individual patients and staff through various situations he makes the text not only intensely interesting, but enables one to view the same problems progressively within different contexts until their significance for the particular hospital (and perhaps for hospitals generally) can scarcely be questioned. In a block of three chapters entitled *Influence of Hospital on Doctor-Patient Relationship*, *Misunderstandings in Administrative Decisions*, and *Occurrence of Collective Disturbances* the focus of attention is upon these aspects of hospital life. At the same time interaction is viewed as increasingly wide in scope: it moves from the physician and patient, to a small group on the ward, to the whole hospital.

The next four chapters deal with perceptions of the hospital as gained from the picture interviews. From them emerge patterns of agreement and disagreement that characterize the ways in which physicians, nurses and patients see the three areas of hospital life and the types of social interaction. Then follows a section on the day-by-day administrative operation of the hospital as determined by the staff meetings Caudill attended. The importance both of status and role in determining what was expressed at those meetings, and how, is emphasized by careful documentation, much of it precise enough to be recorded quantitatively.

From the wealth of material presented space permits us to select only enough of the interrelated themes to suggest the nature and quality of the work.

In reference to the three broad areas of life—therapy, administrative care and human relations—as they were delineated in the hospital at the time it was studied, Caudill makes the following comments. Physicians were primarily concerned with

therapy, discontented if too much time was spent in administrative duties, and frequently uncomfortable in informal human relations with patients. Nurses generally saw themselves as carrying out administrative orders, directed most matters that they defined as therapy to the doctors, and were often uncomfortable in human relations with patients. Patients structured their contacts with each other in terms of human relations, and tended to be uncomfortable when the doctor or nurse stepped out of the therapeutic or administrative role.

Even if emphasis be focused exclusively upon the therapeutic aspect of hospital life, progress in therapy is not solely a matter of relations between doctor and patient. The administrative and the therapeutic process are intimately linked. Difficulties among staff are likely to be reflected in disturbed patient behavior. Perhaps emotional information is transmitted with fewer cues than is cognitive information. Feelings can run through a hospital rapidly. As a consequence, Caudill saw indications of what he designated as "ground swells" which seemed to result in all patients tending to do fairly well at one time and less well at another.

As perceived by the author the hospital under consideration provided several potential sources of satisfaction to which a patient might turn to obtain help with his immediate needs. They were his physician, the nurses and aides, the physical space and facilities of the ward used in ways he found comfortable, other patients, and his own inner resources. The staff took account, however, of only a few of these sources in its effort to understand and help the patient. The communication system provided primarily for the transmission of information about his relations with the medical and nursing personnel. Significant clues about the patient were lost because of lack of awareness of the importance of all

sources of satisfaction, particularly during the crucial period of his first days in the institution.

The physician was likely to be so concerned initially with the patient's history and underlying conflicts that he failed to use advantageously what he might have picked up at the therapeutic sessions about relations with nurses, other patients or the physical environment. The physician, moreover, frequently failed to consult nurses on the wards about these matters, and the latter offered little information at staff meetings, partly because of their status and partly because they had not been charged with responsibility for sharper observation of how patients used potential sources of satisfaction.

The "mobility-blocked" system of the hierarchically structured hospital was the cause of grave difficulties in communication. The amount of talking at staff conferences was directly related to the status of the discussants. Thus, at the conferences observed, senior physicians talked more than residents and four times more than nurses. Even the rather passive resident who spoke the least talked more than the dominant supervisor of nurses. The latter expressed herself, however, more frequently than the staff nurses.

When trying situations arose, like that described in the chapter called Occurrence of Collective Disturbances, all categories of staff had difficulty in communicating with each other. The senior staff appeared to withdraw from the daily routine of decision-making, the residents restricted their focus to their own patients and reduced their interest in the work of the hospital, while the nurses decreased the little they ordinarily said in staff meetings and increased the formalization of their routines. (The patients, meanwhile, increased their intra-group relations and assumed more inde-



pendence in planning their daily activities.) Communication among staff was often charged with expressions of hostility and punitiveness, and little psychological support was accorded either residents or nurses.

Failures in communication detracted from consistent unified planning. Each category of staff tended to work within his own compartment, often with minimum exchange of pertinent conversation. From his observations Caudill noted, for example, that different combinations of staff on duty seemed to produce different effects on diagnostic or social groupings of patients. The combinations found, however, were purely accidental because the chief resident and the nursing supervisor independently scheduled who should be on duty. Whether the therapeutic potential of the hospital could be increased through careful joint planning and experimental testing of ward staffing patterns received no attention.

Caudill concludes: "The conflicts between individual staff members, or between role groups in the staff, are often as important for the understanding of the nature of a problem in the hospital as are the actions of particular patients. If the goal of a therapeutic community is to be reached, there must be a greater openness among staff members than is usually the case at present, and a willingness on the part of the staff to examine their own motivations rather than to project problems onto the patients. This is, perhaps, asking for a good deal, but if it is expected of disturbed patients it is possibly not too much to ask of those who are better integrated. In order to achieve such a state of affairs, however, changes in the organization and atmosphere of the hospital must be made so that neither staff nor patients are punished for their efforts at greater openness and understanding" (pp. 332-33).—ESTHER LUCILE BROWN, Ph.D., Russell Sage Foundation.

## ANALYZING PSYCHOTHERAPY

By Solomon Katzenelbogen

New York, Philosophical Library, 1958. 126 pp.

This is a diminutive volume which bears a catchy, though misleading, title. It does not offer an analysis of psychotherapy. It is, as the author quickly reveals, "what I practice in psychotherapeutic sessions." It is the author's orientation to the task of psychotherapy, influenced by the psychological concepts of Adolf Meyer. "This small book has a big goal." Its purpose is to enlighten patients and prospective patients; it aspires to neutralize the tendency among lay people to equate all psychotherapy with the Freudian method.

The author's conceptual approach to psychotherapy is eclectic. He concerns himself with a range of pertinent themes: the problems of rapport, the variety of techniques, the results of psychotherapy. As is to be expected, he expresses a pointed criticism of some central features of the Freudian analytic method.

Psychotherapy is "talking treatment." It is a 2-person relationship with a special purpose. To fulfill this purpose a therapist requires knowledge of medicine, biology, psychology and sociology. He should have an interest in people, be a good listener, be mature, objective and also be amply endowed with *savoir faire*. His main task is the direct dealing with the patient but the therapist must also concern himself with the environment.

In his critical discourse on Freudian analysis the author raises questions concerning the tendency to overemphasize unconscious mental forces. He believes the importance assigned to sex and childhood conditioning is one-sided and that life experience in adolescence and adulthood may also be crucial to personality disorders. He

is impatient with the "couch" and with the passive role of the analytical therapist. The final chapter on psychotherapy and science is seriously inadequate.

As is the case with all discussions of psychotherapy today, inevitably personal preference and bias play a part. In this book there is some risk also from oversimplification.

The author's urge to discipline himself to an explicit commitment concerning his conception of psychotherapy is commendable. Too few people in the field are willing to divulge what they do.

Despite the author's express wish to be brief and simple, the tone of the book is somewhat pedantic and does not succeed in clearing the air on these many unsolved problems. Angyal once said that "psychiatry is the application of a science which does not yet exist." The practice of psychotherapy is still in great part a personal art. We aspire to give it a scientific foundation but this is still in its birth pangs. The conceptual developments of recent years which permit a more precise formulation of the dynamics of interactional and communication processes offer considerable promise. These more recent studies are not alluded to here. This small book, which sets for itself a "big goal," unfortunately does not offer much enlightenment.—NATHAN W. ACKERMAN, M.D., New York City.

#### CURRENT STUDIES IN PSYCHOLOGY

By F. J. McGuigan and Allen D. Calvin

New York, Appleton-Century-Crofts, 1958. 226 pp.

This volume was designed as a supplementary text for introductory psychology courses. The editors seek to "provide the beginning undergraduate student with an

opportunity to become familiar with some of the current (since 1950) trends in psychological research." They have chosen pure rather than applied studies and have included difficult experiments, but their selection of areas and topics reveals broad interests leaning toward personality, clinical and social psychology.

After a few pages on experimentation and scientific procedure in psychology, the reader starts in on learning studies involving several types of conditioning; compared with much of the experimental work in this area, however, the emphasis is upon human rather than animal research. The section on motivation contains 6 studies, including 2 on anxiety and the relieving of anxiety and one on "the measurement of experimentally induced levels of sexual motivation by a projective test." Part III, on development, starts with a study on the growth of intelligence and moves on to a phase of class differences in child-training practices and an evaluation of sex hormone replacement in aged women. Studies of "facial vision" and of reduced general stimulation on the human being are found among the offerings on perception. The section on personality and behavior disorders has papers on hypnotic age regression, the Eve White case of multiple personality, an assessment of round-table psychotherapy, an experimental study of displacement and two other studies. The five selections on social psychology include research on conformity and character and on interpersonal attitudes of former Soviet citizens, and an analysis of the effectiveness of psychological warfare.

An appendix relates the readings to eight current elementary texts in psychology.

Psychologists are sometimes considered extreme "eager beavers" owing to the stupendous number of research studies, both significant and insignificant, that they pub-

lish. Certainly their output makes the job of selection a difficult one for teachers and for professional workers in allied fields. The editors of *Current Studies in Psychology* are to be congratulated for assembling a group of up-to-date and significant pieces of research which should open the reader's eyes to the wide scope of psychological endeavor.—S. STANSFELD SARGENT, PH.D., VA Hospital, Phoenix.

### MOTHER AND CHILD: A PRIMER OF FIRST RELATIONSHIPS

By D. W. Winnicott, M.D.

*New York, Basic Books, 1957. 210 pp*

The author, a pediatrician and psychoanalyst, addresses his book to the "ordinary, devoted mother." He aims at helping her recognize the importance of her emotional attitude in caring for her young child. He avoids giving restricting advice and telling her what to do or how to feel. His goal is to uncover the genuineness of her feelings, her innate natural knowledge of how to relate to her infant.

In this he succeeds to a large extent. The whole tone of the book is warm and delightfully simple. The many tasks of child care are discussed in situations which confront every mother, including everyday "problems" like jealousy, stealing, telling of lies, and minor illnesses. The author succeeds in delineating the normal range of such deviant behavior from the manifestations of abnormal development.

From what has been said thus far this book should be an ideal companion for the modern young mother. Unfortunately, this it is not. The book is based on talks which were given during the war years over the British Broadcasting Company. It is amazing to note the wide gulf between the

problems of the intelligent young mother in England at that time as compared with what her up-to-date counterpart in America is struggling with today. The straw man of Winnicott's humanistic psychoanalytic approach to motherhood is the "scientific pediatrician" who seems to be bent on repressing a mother's normal feelings, making her approach her baby as if it were a mechanical object. I do not know whether the British pediatrician is, or ever, was such a *bête noir*.

His American colleagues in 1958 would be puzzled by the rigid prescriptions against which Winnicott protects the British mother. In the U.S. the emphasis on permitting emotional expression and indulgence of an infant's needs has been propagated so forcefully that a young mother is faced with the very opposite problem—namely, of producing feelings as a command performance. The resulting perplexity of young parents prompted the reviewer to write a book, seemingly along the same lines as Winnicott's—namely, of helping mothers to look upon their task with trust and confidence and of protecting them from unreasonable "scientific" demands which here, in the U.S.A., were forced upon her by aggressive psychological experts.

There is one inner inconsistency in this stimulating and reflective book: The author states repeatedly that he, a mere man, could never really understand and know how a mother feels about her child, her own flesh and blood. At the same time the book abounds with definite statements and vivid descriptions on how "the infant" feels or what "the baby" experiences or expects in any given situation. This anthropomorphism is the more astounding because the difficulty of knowing another person's feelings has been so clearly recognized.

Winnicott's book is of historical and cross-cultural interest, reflecting the struggle to



find a sound balance between the physiological and psychological aspects of child care.—HILDE BRUCH, M.D., New York City.

LOVE, SKILL AND MYSTERY:  
A HANDBOOK TO MARRIAGE  
By Theodor Bovet

New York, Doubleday & Company, 1958. 188 pp.

Dr. Bovet, a Swiss physician who has apparently specialized in marriage counseling, wrote a previous book on this subject in 1947, *Marriage, Its Crises and Potentialities*. This text, written in German, was revised in 1956 and republished in Europe where, according to the dust cover statement, 100,000 copies have been sold. It has now been translated, and quite well, into English, and was published in this country in June 1958.

It is quite evident from reading the book that the author is well-informed, has had wide experience, is something of a philosopher as well as a physician, has very definite convictions, and is a deeply religious man. Furthermore, he writes well, and his book is quite readable. There is a great deal of practical information, wise advice and inspiration for young unmarried people, the newly married, and the long-married, and one welcomes this small volume as a thoughtful contribution to the literature on marriage. There is very little psychiatric terminology, although the author appears to be fairly well informed about dynamic psychiatry. He quotes only one psychiatrist, Dr. Helene Deutsch, and her only once, but there are many quotations from sociologists and other marriage counselors, and a great many Biblical references.

Dr. Bovet's convictions include complete opposition to premarital coitus—even to

sexual arousal before marriage—and practically complete opposition to divorce. His strong position is that marriage is not to be entered into lightly in the first place, and that marriage is for life. One would doubt, from reading his book, that he would ever regard a marriage, however much it might seem to be on the rocks, as unsalvageable. In these views he takes a profoundly religious point of view, probably more Catholic-oriented than Protestant-oriented, although in one section he tries to show that the Catholic and Protestant views about divorce are much closer than is usually supposed. At some points in his exposition, particularly in the last two chapters, he displays a religious devoutness that may, to some readers, somewhat obscure the advice he is giving. "Following God's will" in various marriage crises may prove to be rather nebulous advice for many people who are troubled about their marriages.

Throughout the book, however, there is a wealth of practical advice, earthy wisdom and clear information. Contraceptive methods are explained in detail, coital positions are described, and techniques of love-making are explained; there is even a proposal, though an autosuggestion fantasy, for control of timing of the husband's orgasm—given as a possible cure for *ejaculatio praecox*. He includes the clearest explanation of the Rh factor in layman's language that this reviewer has ever seen. His view about hereditary factors, especially about the inheritance of mental illness, may be too organically weighted for some readers, as it was for the reviewer, and may unduly alarm many people who have experienced mental illness or whose near relatives have.

With the few reservations noted, however, one may safely recommend this book to young people contemplating marriage, to happily married couples and to couples who

are worried about their marriages. All will find it deeply thoughtful, rich with both down-to-earth and inspirational wisdom, and genuinely helpful.—ROBERT P. KNIGHT, M.D., Austen Riggs Center, Stockbridge, Mass.

## THE STORY OF HUMAN EMOTIONS

By George M. Lott

*New York, Philosophical Library, 1958. 225 pp.*

Dr. Lott has written a book for the general public describing the development of the human personality and explaining why people feel and act as they do. His stated purpose is to lead his readers to their optimal personal social adjustment through an understanding of themselves. He writes from a background of many years' clinical experience as a psychiatrist and counselor of young persons.

The volume, as a whole, covers the subject in fairly comprehensive fashion, in language which is refreshingly free of technical terminology. The points Dr. Lott wishes to make are abundantly illustrated with anecdotes and case material. A generous sprinkling of cartoons, largely from well-known popular magazines, highlights some of the more important topics.

This is, of course, one of many books dedicated to a similar purpose, and the reader inevitably looks for its particular significance in a heavily competitive field. The subtitle suggests that it is written from a "teenage viewpoint," but this is by no means obvious as one carefully reads the numerous chapters. Much of the material follows a fairly conventional path of advice to parents about their children.

While the book as a whole covers most of the important points regarding human emotions, the individual sequences and

transitions of individual passages are not always clear. The arrangement of subheadings is particularly inconsistent. Throughout the book, generalizations are frequently obscured with a barrage of anecdotes and quotations which seriously detract from the clarity of the total presentation. There are numerous humorous references, many of which highlight particular aspects of the material in a very helpful way. However, the humor is likewise inconsistent and ranges from the light to the heavy, the relevant to the farfetched.

A most unfortunate chapter a third of the way through the book, contributed by a collaborator and purporting to summarize previous material, includes numerous terms such as "diabolical brats" and parents who "have made a mess of the child already." This section is quite out of tune with the tenor of the whole volume, and one wonders why it was included.

Dr. Lott has made a serious and sincere attempt to discuss human emotions in such a way that the reader may derive personal assistance from what he peruses. The success of the volume would appear to hinge on whether or not the author's particular mode of presentation is clear enough and forceful enough to really impress those whom he addresses.—CHARLES BRADLEY, M.D., University of Oregon Medical School.

## CLINICAL STUDIES IN CULTURE CONFLICT

Georgene Seward, ed.

*New York, Ronald Press, 1958. 598 pp.*

In the behavioral sciences and art it has always been stressed that a person can be understood only by recognition and appreciation of all of the forces which have been interacting to make him the individual that

he is. The training program of social workers frequently utilizes study of actual case records which emphasize such factors as cultural characteristics to illustrate how these are integrated into the personality structure. Now there has been published a volume which serves the same purpose for the clinical psychologist in training.

*Clinical Studies in Culture Conflict*, edited by Georgene Seward, Ph.D., consists of 22 case presentations by a number of psychologists, psychiatrists and social anthropologists. The patients range from an English war-bride coming into an American-Armenian family to a Navajo Indian who was a quadriplegic as the result of an automobile accident. By case histories, detailed protocols and in some instances therapeutic progress reports, the reader is given valuable insights into the interplay of forces which resulted in the particular individual under study. One sees the character structure in a new dimension and thus can more clearly define how help might be given.

It must be pointed out that this book does not attempt to show the development of specific character structure in the matrix of a particular culture or as the result of cultural stress. This apparently was done by the editor in a previous work and the present volume then becomes a series of illustrations for that study. It may well be that the two volumes should be read together to obtain the maximum usefulness from both.

Since the emphasis here is on cultural conflicts, one should not perhaps ask for more. However, it is the reviewer's opinion that the focus on cultural clash is not sufficient and one must also elaborate on the interaction of cultures with growth and the appearance of new qualities. With such an approach, the editor might have avoided the gross error of his statement that "the Negroes have no specific culture of their

own, beyond the forgotten echoes of African drums . . ." The interpenetration of the African and American cultures in the formation of a unique Negro culture is a fascinating story which has been repeatedly told.

There are statements in this work which struck the reviewer as rather rigid and too close to stereotypes to be comfortable. However, one can be more impressed by the warmth of feeling for the patients which shows through the histories and data, and thus the end result is a definite contribution towards the aiding and benefiting of the troubled.—LEO H. BERMAN, M.D., Green Farms, Conn.

#### INTERDISCIPLINARY TEAM RESEARCH METHODS AND PROBLEMS

By Margaret Barron Luszki

New York, New York University Press, 1958. 355 pp.

This timely volume is concerned with interdisciplinary research, including its definition, the advantages and disadvantages of such teamwork, as well as the theoretical aspects and practical details involved in interdisciplinary studies. The choice of the term *interdisciplinary* rather than *multidisciplinary* is apparent because of the interactions between proponents of different fields implied by the former. A team of investigators can tackle larger problems than can individuals; time is saved and more variables can be controlled by the simultaneous efforts of a group.

The author wisely reemphasizes the different viewpoints of scientists and practitioners as a possible cause of friction. The scientist is ready to go contrary to accepted standards, while the medical man will do nothing to jeopardize the patient. The author concludes that "unless structural



ways can be found to circumvent this difficulty, any group projects which involve asking therapists to do research is likely to come to grief."

Specific training is advised for interdisciplinary work. Such training can readily be accomplished at the graduate level but is not a part of the training for the M.D. degree, and the problem of training psychiatrists for interdisciplinary research is therefore more difficult.

Among the practical problems considered is the task of selecting people for participation. The author concludes that it is desirable for each member of the team to be somewhat dissatisfied with the limits of his own discipline and to feel the need for collaboration. The responsibilities of the research leader, the difficulties of administration and the choice of the administrator are also analyzed.

From this enumeration of some of the high spots of the volume, it can be seen that it is essentially a thoughtful consideration of many of the questions concerned with a method of investigation which is widely employed. The book is recommended reading for all investigators and administrators involved in interdisciplinary teamwork. A valuable bibliography classified according to subject is included.—HAROLD E. HIMWICH, M.D., State Research Hospital, Galesburg, Ill.

## ORTHOPSYCHIATRY AND THE SCHOOLS

Morris Krugman, ed.

New York, American Orthopsychiatric Association, 1958. 265 pp.

In spite of its multidisciplinary approach and its great concern with children, "orthopsychiatry has been overwhelmingly involved in clinics, hospitals, treatment centers and social agencies, and only obliquely concerned with schools," Dr. Krugman says in his introduction to *Orthopsychiatry and the School*. Krugman makes the further comment that even when orthopsychiatry did deal with schools, "it was generally to tell schools what to do for specific children under study or treatment by a clinic or team."

This volume should be of practical help to people in education who are concerned with mental health and what schools can do about it. The 26 papers in the volume are organized in 5 sections: orthopsychiatry's help to education; orthopsychiatry and problems of learning; orthopsychiatry and school mental health; teacher education and mental health; and orthopsychiatry and adolescent problems. Two of these sections were symposia at the 1956 and 1957 meetings of the association.—W. CARSON RYAN, Chapel Hill.

# Notes and Comments

## RESEARCH

The second list of grants made by the National Association for Mental Health under its expanding research program have been announced by Dr. William Malamud, research director.

The grants were made to 8 research scientists by the NAMH research committee at a meeting June 22. The names of the investigators, the titles of their projects and the amounts of the grants follow:

• Dr. Martin L. Pilot, Yale University, \$1,000 for a study of discordance in the development of certain mental and physical illnesses, particularly psychosomatic illnesses, in identical twins.

• Sarnoff A. Mednick, University of Michigan, \$11,867 for an investigation of learning and thinking in schizophrenia.

• William E. Broen, Jr., and Lowell H. Storms, Neuropsychiatric Institute of UCLA, \$4,538 for research relating behavior theory to schizophrenic thinking.

• Dr. Justin M. Hope, New England Center Hospital, Boston, \$15,000 for a study of aldosterone excretion in behavioral disorders.

• Dr. Floyd S. Cornelison, Jr., University of Oklahoma School of Medicine, \$12,000 for a study of the effects on mental patients of a sound-film record of their own abnormal behavior.

• Joseph J. Noval and Arthur Sohler, New Jersey Neuropsychiatric Institute, \$5,300 for an investigation of the metabolism of adrenochrome and adrenolysin in animals and man.

These grants bring to \$98,444 the amount allocated by the NAMH research committee since its inception a year ago.

## CARE AND TREATMENT

From the *New York Times*, June 24, 1959: "The State Department of Mental Hygiene reported today that a decentralization program was being undertaken at Pilgrim State Hospital in West Brentwood, L. I.

"The objective, according to Dr. Paul H. Hoch, the commissioner, is to achieve the advantages of a small hospital within the framework of a large institution.

"Pilgrim has 14,000 beds and is considered to be one of the largest institutions of its kind in the world. Under the new plan, the hospital will be broken up into several small coordinated hospitals, a cluster of units with 2,000 to 3,000 beds each.

"Each unit will be supervised by an assistant director who will perform both clinical and administrative functions. Each unit will be self-contained, with its own admission service, treatment facilities and release procedures. However, such institution facilities as transportation, maintenance and the business office will be shared.

"Two of the small units already have been established, and it is hoped that five more may be operating shortly."

\* \* \*

The first patients would be admitted shortly to New York's state research unit in narcotic addiction, Commissioner of Mental Hygiene Paul H. Hoch revealed in June.

There are 55 beds for inpatients at the research center, Dr. Hoch said. In addition, about 150 outpatients will be treated. In the course of a year several hundred patients can be treated.

The unit, located at Manhattan State Hospital, Wards Island, New York City, is the first full-time narcotics research unit in the state combining laboratory, outpatient and inpatient operations. It has been

organized for research purposes and will concentrate on basic investigations in an effort to determine primarily the causes of narcotic addiction and to develop better treatment methods. The work of the center will be integrated with the new program of treatment and clinical research to be conducted by New York City.

"In addition to the social and psychiatric problems in drug addiction, which are to a considerable degree known, this research will concentrate on biological factors to try to find a clue to the craving for drugs," Dr. Hoch said. "It is this aspect of the addiction which offers the most challenging problem and the one that must be solved if drug addiction is to be controlled."

\* \* \*

A special project combining group counseling of trouble-susceptible adolescents with parent education for their mothers and fathers has been set up for 5 Long Island communities. The project is a joint enterprise of the Mental Health Association of Nassau County, N. Y., the Nassau County Mental Health Board, the North Shore Child Guidance Center and the school systems of Great Neck, Manhasset, Port Washington, Roslyn and East Williston.

Immediate help is offered to troubled boys and girls from 14 to 16 who would not ordinarily be reached by any counseling service. Families who can afford it are charged a modest monthly fee based on their ability to pay.

The teen-agers meet once a week in groups of 7 to 9. Their parents attend monthly sessions. The schools are taking the responsibility of case-finding and make the initial arrangements with the adolescents and their parents.

\* \* \*

Further confirmation that penicillin is effective against syphilitic psychosis was re-

ported in May in the *Archives of Neurology and Psychiatry*.

More than 80% of persons whose brains are damaged by syphilis can return to work if they receive penicillin in the early stage of the brain damage, a new study has shown. Even the severely affected or institutionalized patient has one chance out of three for improvement and rehabilitation if given penicillin.

The study, dealing with 1,086 patients suffering from brain damage (paresis) covered more than five years and was conducted in eight major hospitals.

Penicillin is the standard treatment for syphilis and if given early will prevent paresis altogether, the report said. None of the 1,086 patients had received penicillin for early syphilis.

The study showed that in most instances only one course of treatment with penicillin is necessary to favorably affect the course of paresis. Retreatment appears to exert little effect.

The effect of penicillin on individual symptoms and signs of paresis are, in general, "strikingly beneficial," the report said. Disorientation, depression, convulsions, tremors, incontinence, impaired handwriting and other symptoms were greatly improved by the use of penicillin. However, impairments of speech, insight, calculation, judgment and general information do not entirely disappear, the report said.

Nevertheless, many patients with paresis can be rehabilitated and returned to work. The sooner the diagnosis is made and treatment begun, the better the chances of the person returning to a fairly normal life, the report said.

The senior author of the report was Dr. Richard D. Hahn of Johns Hopkins Hospital, Baltimore.

\* \* \*



The Veterans Administration is changing its mental hospitals into "open-door" treatment communities, the agency announced in August.

A large number of the patients live and work at the hospitals and come and go about the hospital grounds and towns nearby, much as they would if they lived in any community, while they continue to receive hospital treatment.

Dr. Jesse F. Casey, director of the VA psychiatry and neurology service in Washington, D. C., said the development is in line with the best modern concepts of psychiatry and is doing a great deal of speed recovery of patients. He said "open-door" mental hospitals have reported fewer patients leaving against medical advice, fewer acts of hostility, and higher discharge rates than "closed" mental hospitals.

The VA "open-door" policy is backed by an active treatment program involving extensive orientation of the entire staffs of the hospitals and assistance of volunteers from nearby communities, Dr. Casey said.

However, he said not all patients are able to accept the responsibility of more freedom, and therefore it is necessary for the hospitals to maintain supervision for these patients in closed wards. Granting of the maximum practicable amount of personal freedom is a major factor in rehabilitation of psychiatric patients, Dr. Casey explained, as it gives them opportunity to learn to make their own decisions and adapt to new situations. Many are able to participate in work-therapy assignments and make occasional visits to their homes as a preparation for return to life outside the hospital, he added.

Some 20,000 patients are treated each month at VA mental hygiene clinics as outpatients. More than 65 VA general medical and surgical hospitals have sections for short-term treatment of psychiatric patients.

## REHABILITATION

Continued efforts by the New Jersey Association for Mental Health to bring about the deletion of the word *physically* from the name of the Governor's Committee on Employment of the Physically Handicapped have been successful.

. . . .

Placement of recovering mental patients in foster homes is now giving the Veterans Administration the equivalent of a 1,500-bed mental hospital, the VA reported last May.

The agency's foster home program was started in 1951 to expand its psychiatric rehabilitation program, especially for veterans hospitalized for a long time. It allows recovering mental patients to live in a home environment as a step in their return to the community.

The VA said 1,554 patients lived with "adopted" families in private homes near VA hospitals during 1958, a 24% increase over the 1,249 in foster homes in 1957 and a 53% increase over the 1,011 in foster homes during 1956.

The hospitals placed 807 patients in foster homes during 1958. A total of 328 of these recovered sufficiently during the year to be discharged from the hospital rolls.

## TRAINING

As part of the national trend toward providing more psychiatric information for every physician, no matter what his specialty, WTVS, Detroit educational television station, recently presented a 10-week series of programs under the general title of Psychiatry in Medicine. They were planned by the psychiatry department of the Wayne State University College of Medicine in cooperation with the psychiatry department of the Detroit Receiving Hospital.

Among the topics were depression, the

suicidal patient, the psychology of convalescence, emotional problems of children, psychiatric emergencies, alcoholism and drug addiction.

\* \* \*

Since February 1959, when the American Board of Psychiatry and Neurology was authorized to undertake certification in child psychiatry, six physicians have been certified in the sub-specialty. All are diplomates in general psychiatry. They are Dr. Frederick H. Allen, Philadelphia; Dr. Frank J. Curran and Dr. William S. Langford, New York; Dr. Othilda Krug, Cincinnati; Dr. Hyman S. Lippman, St. Paul and Dr. Joseph Franklin Robinson, Wilkes-Barre.

\* \* \*

Growing interest in psychiatry in the medical profession itself is reflected in a statistic from the University of Washington. Nine of last year's medical class of 70 plan to specialize in psychiatry—a far higher percentage than in the past.

\* \* \*

In an attempt to attract college students to careers in mental health, the Kentucky Department of Mental Health placed ads this spring in 13 college newspapers. The ads called attention to stipends offered by the department to graduate students interested in becoming psychiatric social workers, psychologists and occupational therapists. They were scheduled in 6 college papers in Kentucky, 3 in Mississippi, 2 in Tennessee, 1 in Florida and 1 in Indiana.

"The response has been gratifying," Commissioner H. L. McPheeters reports. "We feel we've found a good way of publicizing our efforts to train more mental health workers."

## APPOINTMENTS

Dr. Harvey J. Tompkins has been elected president of the Academy of Religion and

Mental Health. He is director of psychiatry for St. Vincent's Hospital, New York City.

The academy is a national educational and research organization with headquarters in New York. It endeavors to integrate the moral values of religion and the scientific insights of psychiatry and the behavioral sciences.

\* \* \*

Dr. Eli Ginzberg, Columbia University economics professor, and Dr. John C. Whitehorn, director of the psychiatry department at the Johns Hopkins University School of Medicine, have been appointed to the National Advisory Mental Health Council for 4-year terms. The council advises Surgeon General Leroy E. Burney of the U. S. Public Health Service on programs of the National Institute of Mental Health.

\* \* \*

Dr. Arthur P. Noyes, internationally known psychiatrist, resigned from his post as superintendent of Norristown, Pa., State Hospital on June 12 but remains in state service in a newly created position as director of professional education and consultant to the Commissioner of Mental Health.

In the 23 years Dr. Noyes was at Norristown, his reputation and teaching skills were responsible for attracting many young psychiatrists to state service. In his new post he is responsible for coordinating psychiatric residency programs, with particular emphasis on the development of a training program in mental hospital administration.

Dr. Noyes, who is 79, is a past president of the American Psychiatric Association, and the author of several well-known text books in psychiatry.

## AWARDS

The Veterans Administration Chief Medical Director's Commendation, highest award

given by the VA Department of Medicine and Surgery, has been presented to Dr. Erwin W. Straus of the agency's Lexington, Ky., hospital.

Dr. Straus was cited for his outstanding contributions to the VA patient care and medical research programs and for his contribution to psychiatry through his writings, lectures and exhibits.

As director of the research and education service of the Lexington hospital, he has worked closely with the VA's large-scale cooperative studies of chemotherapy in psychiatry since these were begun in 1954. He is also engaged in extensive research of his own, studying expressions, gait, gestures and other behavior of mentally ill patients.

\* \* \*

Dr. Alvin I. Goldfarb, a pioneer in psychotherapy for the aged, was honored last May by the retired members of District 65, Retail, Wholesale and Department Store Union, ALF-CIO.

He was cited for "re-examining old ideas and developing new theories by exploring with new techniques ways of bringing relief and hope to the mentally ill older patient. As a result of his work thousands today can remain in their communities or in homes for the aged instead of having to be sent to mental hospitals, where the door frequently closes forever."

Dr. Goldfarb is director of psychiatric and neurological services at the Home for Aged and Infirm Hebrews and special consultant on aging to the New York State Department of Mental Health.

Dr. George S. Stevenson, editor of *MENTAL HYGIENE* and consultant to the National Association for Mental Health, received a similar award from District 65 a few years ago.

## MEETINGS

Physicians, psychiatrists, legislators and members of the Southern Regional Education Board meet in Atlanta October 8-9 to discuss methods of supplying information about psychiatric principles to physicians who are not psychiatrists.

Attending the region-wide conference are representatives from state medical associations, academies of general practice, psychiatric associations and medical schools, along with key legislators and physicians and psychiatrists in private practice.

\* \* \*

Although facilities, regulations and methods for the care of the mentally ill may differ from country to country, participants in a recent World Health Organization conference in Helsinki unanimously agreed on the aims of mental health services:

- Better treatment inside and outside hospitals with more patients being cured more rapidly.
- Better educational facilities for handicapped children so as to prevent their becoming institutionalized cases.
- Earlier detection of mental illness, through medical services and general practitioners, but also through teachers, social workers, judges and police officers.
- Reduction of stress in the environment as a means of prevention, especially in the institutions for children and the old.
- Increased understanding of mental health problems by the public, the public authorities and health workers generally and increased tolerance in society for odd behavior.
- More research.

About 60 psychiatrists, general practitioners, nurses, social workers and psychologists from 26 European countries attended the conference. It was convened to determine the general principles of mental hy-



giene applicable in all the countries of Europe. Prof. Arie Querido of Amsterdam was chairman.

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The second annual meeting of the Society for the Scientific Study of Sex is set for November 7, in the Barbizon Plaza Hotel, New York City. The program consists of two symposia, one on the psychological factors in infertility, the other on the question of what is sexually normal.

Further information is available from Robert V. Sherwin, Suite 704, 1 E. 42nd St., New York 17.

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Thirty-five western leaders in mental health attended the second annual meeting of the Mental Health Council of the Western Interstate Council on Higher Education in San Francisco, June 18-20.

Two administrators from the Langley Porter Neuropsychiatric Institute—Dr. Alexander Simon, medical superintendent, and Dr. Klaus Berblinger, chief of clinical services—described a new joint WICHE-Langley Porter program of postgraduate psychiatric education for western physicians. Under the direction of Dr. Berblinger and Dr. Warren Vaughan, WICHE's new mental health project director, a 10-week series of seminars will be given to groups of local physicians in general practice, pediatricians, internists and surgeons. Each seminar group will meet once a week and will stress the typical psychiatric problems encountered in a physician's practice.

During the first year of the program, teaching units will be set up in four western cities. The faculty of each unit will consist of two qualified psychiatrists approved by local medical societies. All of the psychiatric teachers will attend an intensive two-day institute at Langley Porter.

The Mental Health Council also:

1. Created a committee to plan a program of mental health traineeships.

2. Approved a proposal to set up machinery for a western advisory service in mental health research.

3. Endorsed a regional training and research program in the field of mental retardation.

4. Approved plans for a conference on in-service training for directors of psychiatric nursing services.

5. Approved a proposal for a multidisciplinary conference of the directors of university training programs in psychiatry, social work, psychology and nursing.

6. Recommended that the WICHE mental health newsletter be continued on a regular basis.

7. Appointed former Governor Milward Simpson and Dr. Herbert Gaskill to consider the possible application of the Western Interstate Corrections Compact to methods of dealing with the mentally ill.

Albert Deutsch, well-known writer and mental health expert, was the principal speaker at the council meeting. Speaking on "New Directions in Mental Health Research," Mr. Deutsch deplored the growing tendency to look to the federal government as the dominant source of financing mental health research. He contended that "the states and localities, along with appropriate voluntary agencies and foundations in the field, cannot evade their own responsibilities for developing and supporting more research effort. Even if the federal government could finance the entire field, it would be dangerous to independent scientific investigation to allow one source to dominate it. We need cooperation, but we need friendly competition, too."

\* \* \*

Psychiatric problems of the aging, including those who are mentally defective, will

be the main topic of the American Psychiatric Association's 11th mental hospital institute. It will be held October 19-22 in Buffalo.

The principal speaker will be Rep. John E. Fogarty, chairman of the House of Representatives' subcommittee on labor, health, education and welfare. His address is titled "Economics, Ethics and Mental Illness."

A special feature of the final session will be a question period called "Hospital Psychiatry Meets the Press." Newspapermen and hospital psychiatrists will query each other along two general lines: "The Press—Help or Hindrance in Fighting Mental Illness?" and "Are We Making Progress Against Mental Illness?"

The institutes are held annually by APA to give U. S. and Canadian mental hospital workers a chance to talk over common problems.

\* \* \*

Methods of streamlining the reporting of mental health statistics to facilitate research were discussed recently by statisticians and key mental health officials from 16 southern states and the National Institute of Mental Health. The region-wide conference, held in Atlanta, was sponsored by the Southern Regional Education Board's mental health program.

"This is the first time mental health statisticians from all southern states have had an opportunity to compare notes on how data is collected in each state," Dr. Harold McPheeters, Kentucky mental health commissioner and conference chairman, pointed out. "This meeting gave them a chance to exchange information about ways of making facts and figures uniform so that reports of one state will be comparable with those of another."

According to Dr. Wm. P. Hurder, SREB associate director for mental health, there

are two main advantages to a unified mental health accounting system: (1) it makes it easier for administrators to compare their operations with those of other states and (2) it opens up new research possibilities for administrators and researchers.

At the present time the reported cost of patient care, for example, varies with almost every state since statutes defining elements of the budget vary from state to state. Cost per patient per day often reflects such variable items as whether or not clothing is furnished to patients or room and board are provided for personnel. These figures therefore are not an accurate index to the amount of money spent for care and treatment of patients in different states, Dr. Hurder explained.

As one method of unifying reporting procedures, participants discussed the Model Reporting Area—a cooperative effort among states and the National Institute of Mental Health in reporting mental statistics. Of the 21 states in the nation in the Model Reporting Area, 7 are in the southern region. Other southern states are now making plans to join MRA.

A committee was appointed to work further with the SREB to investigate methods of coordinating the reporting of statistics in the South. Mr. Cecil R. Wurster, chief of research for the Louisiana Department of Hospitals, was elected chairman by the group.

\* \* \*

The American Psychosomatic Society will hold its 17th annual meeting at the Sheraton-Mt. Royal Hotel in Montreal, March 26-27, 1960.

The program committee would like to receive titles and abstracts of papers for consideration for the program no later than December 1, 1959. The time allotted for presentation of each paper will be 10 or

20 minutes. Abstracts of two or three pages, in nine copies, should be submitted for the committee's consideration to Dr. Eric D. Wittkower, chairman, 265 Nassau Road, Roosevelt, N. Y.

\* \* \*

The mental health commissioners of 34 states have formed the National Association of State Mental Health Program Directors. They plan to incorporate as a nonprofit organization in the District of Columbia and to hold their first annual meeting October 19 in Buffalo during the 11th Mental Hospital Institute.

The officers, elected April 29 in Philadelphia, are Dr. George Jackson of Kansas, president; Dr. Clifton T. Perkins of Maryland, vice-president, and Dr. Harold McPheeters of Kentucky, secretary-treasurer. Three were elected to the executive committee: Dr. J. B. K. Smith of Alaska, Dr. V. Terrell Davis of New Jersey and Dr. Dale C. Cameron of Minnesota.

## PUBLICATIONS

The continued decline in the number of patients resident in mental hospitals is spelled out in Fact Sheet #9 of the Joint Information Service co-sponsored by the National Association for Mental Health and the American Psychiatric Association. At the end of fiscal 1957, a total of 787,525 patients were in mental hospitals. During the year, 514,134 had been admitted, 450,156 discharged.

Copies of the Fact Sheet are available from NAMH, 10 Columbus Circle, New York 19.

\* \* \*

The Society for the Scientific Study of Sex will publish a new periodical, *The Journal of Sexual Research*. The first issue will appear early in 1960.

The journal is to include original arti-

cles, reviews of the literature, book reviews and abstracts covering the range of all the learned disciplines pertinent to the study of sex. Papers should be submitted to Dr. Hugo G. Beigel, 138 E. 94th St., New York 28.

\* \* \*

Volume 1, Number 1 of the *Archives of Neurology* appeared in July. The new journal is published monthly by the American Medical Association, with Dr. Harold G. Wolff of New York as chief editor.

Its primary aim, according to the first editorial, "is to further knowledge of clinical neurology, and thus to advance neurological science in general."

Manuscripts that make genuine contributions to the understanding of clinical phenomena, including diagnosis, etiology, symptoms, signs and treatment, and of the factors that modify their course are to be given high priority, according to Dr. Wolff. Also included in this category are manuscripts that deal with the setting in which disease occurs.

"Insofar as manuscripts describing neuropathological material, or chemical, physiological, neurosurgical, electroencephalographic or psychological studies clearly illuminate neurological clinical states, they will be given preference," Dr. Wolff writes.

Subscription rates for the new periodical are \$14, domestic; \$14.50, Canadian; \$15.50, all other countries; \$8, students, interns and residents in the U. S. and its possessions.

\* \* \*

The national mental health survey conducted the last three years by the Joint Commission on Mental Illness and Health was officially terminated June 30, 1959. The commission's findings and recommendations for a national mental health program will be set out in a series of 10 monographs and a final report.



Three monographs have already been published—on concepts of positive mental health, the economics of mental illness and the recruitment of psychiatric manpower. Others, to be published within the next few months, will be titled *Americans View Their Mental Health: A Nationwide Opinion Survey*, *The Role of Schools in Mental Health*, *Research Resources in Mental Health*, *Religion in Mental Health*, *Community Resources in Mental Health*, *Epidemiology of Mental Illness* and *The Mental Patient and His Care*.

For the final stages of its work, the commission has moved to offices at 74 Fenwood Road, Boston 15.

\* \* \*

Information for applicants for certification in child psychiatry has been published by the American Board of Psychiatry and Neurology and is available in pamphlet form from the secretary, Dr. David A. Boyd, Jr., 102-110 Second Ave., S.W., Rochester, Minn.

\* \* \*

A survey of salaries for professional positions in psychiatric clinics and hospitals in 1958 has been completed by the Des Moines Child Guidance Center.

The study, based on a nation-wide sample, describes salary levels and ranges in relation to the training and experience required for each type of job. It compares salaries in 1958 with those reported in a similar study made by the center in 1955.

Copies of the current study are available at cost (single copy, 25¢; 10 or more, 15¢ each) from the Des Moines Child Guidance Center, 500 Garver Building, Des Moines 9, Iowa.

\* \* \*

The first number of a new psychiatric periodical, *Journal of Neuropsychiatry*, was to appear in September 1959. It will re-

iterate the purpose of the American Society of Medical Psychiatry:

- To promote study of the disorders of the function of the brain called mind and to promote its healing.
- To promote study of the effects of pharmacological, biological, immunological and other physical agents on the human brain.
- To further study of treatments of neurological, psychiatric and allied diseases.
- To stimulate and encourage research and training among members of the medical profession.

Dr. L. J. Meduna, Chicago, will serve as editor-in-chief. Dr. A. I. Jackman, Chicago, and Dr. A. A. LaVerne, New York, will be the editors. The advisory board of international experts includes Dr. Juan F. López Ibor, Madrid; Dr. Gabriel Langfeldt, Oslo; Dr. A. C. Pacheco e Silva, São Paulo; Dr. Hans Hoff, Vienna; Dr. Francis J. Gerty, Dr. Frederick A. Gibbs and Dr. Leo A. Abood, all of Chicago.

During its first years the journal will be published bimonthly. The annual subscription fee has been set at \$10 for the six issues.

\* \* \*

The realities of the mental health manpower shortage are the subject of a study released in June by the Joint Commission on Mental Illness and Health.

The study comes to the conclusion that sufficient professional personnel to eliminate the glaring deficiencies in public care of mental patients will never be available if the U. S. population continues to grow without a parallel increase in the recruitment and training of mental health manpower.

Only a great change in social attitudes and a consequent massive emphasis on education or a sharp breakthrough in research on mental illness will change this negative outlook, according to the study.

Most of the 350-page report, titled *Mental Health Manpower*, is devoted to an analysis of the causes of the shortage of psychiatrists, psychologists, psychiatric nurses and psychiatric social workers needed to provide first-class treatment for the mentally ill.

The study was written by Dr. George W. Albee, Western Reserve University psychology professor. It was published by Basic Books (59 Fourth Ave., New York 3), and is available from the publisher or from book dealers for \$6.75.

\* \* \*

Miss Dorothy Donaldson, editor of *Recreation Magazine*, has announced that two pages have been added to the publication, to be used only for notes on recreation therapy for the ill and handicapped. Those interested in this field are invited to contribute.

\* \* \*

Recent community mental health laws are reviewed in a new publication of the Joint Information Service co-sponsored by the National Association for Mental Health and the American Psychiatric Association.

Most of these laws embody four significant principles, the study shows:

- They are permissive rather than mandatory.
- They provide for comprehensive, well-rounded local mental health programs under a local board, with the state providing advisory service.
- They put the responsibility for the program on the community and make the director responsible to the community rather than to the state.
- And they make the state responsible for up to one-half the cost of the program if

certain standards are met and certain procedures are followed.

The study analyzes in some detail the community mental health laws of New York, California, Minnesota and New Jersey, and briefly discusses those of Vermont, Indiana and Tennessee.

Several questions have arisen in administering the laws, the Joint Information Service points out. How do you define a mental health service? Shall preventive as well as treatment programs be included? How should responsibilities be divided among state government, local government and voluntary agencies? Should psychiatric care of the aged be included? What should be the relationship between community mental health programs on the one hand and community activities carried on by state mental hospitals on the other? What should be the relationship of the community mental health program to organized medicine and the private practice of psychiatry? And finally, where do you get enough professional personnel to man new community mental health facilities?

A bibliography is included in the study.

Copies of the fact sheet (No. 8) are available from the National Association for Mental Health, 10 Columbus Circle, New York 19.

\* \* \*

The national mental health survey conducted by the Joint Commission on Mental Illness and Health the last three years officially terminated June 30, 1959. Its findings and recommendations for a national mental health program will be set out in a series of 10 monographs and a final report:

- *Current Concepts of Positive Mental Health*, by Marie Jahoda (Basic Books, 1958, \$2.75). This monograph has had an excellent reception since its publication

last fall. It has helped clear the air on what is meant by "mental health." Approximately 6,000 copies have been distributed.

● *Economics of Mental Illness*, by Rashi Fein (Basic Books, 1958, \$3). This likewise has been well reviewed and generally acclaimed as a valuable contribution to the understanding of costs. Approximately 3,000 copies have been distributed.

● *Mental Health Manpower Trends*, by George W. Albee. Basic Books released this monograph, the first product of the commission's larger study projects, in June 1959. It is expected to command a great deal of attention.

● *Americans View Their Mental Health: A Nationwide Opinion Survey*, by Gerald Gurin, Joseph Veroff and Sheila Feld, Survey Research Center. This much-anticipated study of what people say troubles them and what they do about their troubles should be available in the fall.

● *The Role of Schools in Mental Health*, by Wesley Allinsmith and George W. Goethals. This study, carried out at the Harvard University Graduate School of Education, will be published in the fall.

● *Research Resources in Mental Health*, by William F. Soskin. This will be published in the early winter.

● *Religion in Mental Health*, by Richard V. McCann. This provocative study, conducted under a grant from the Rockefeller Brothers Fund, will also be published in the fall.

● *Community Resources in Mental Health*, Reginald Robinson, David F. DeMarche and Mildred K. Wagle. This will be published in late fall.

● *Epidemiology of Mental Illness*, by Richard J. Plunkett and John E. Gordon.

● *The Mental Patient and His Care*, by Morris S. Schwartz, Charlotte Green Schwartz, Mark G. Field, Elliot G. Mishler, Simon S. Olshansky, Jesse R. Pitts, Rhona Rapoport and Warren T. Vaughan, Jr. This monograph, covering not only the care of hospital patients but outpatients and ex-patients, will be published in the winter.

● *The Final Report*. It appears quite probable this will be published simultaneously with Monograph 10, *The Mental Patient and His Care*.

#### MISCELLANEOUS

One of the most unusual collections of paintings in the nation now hangs in the national headquarters of the American Psychiatric Association in Washington, D. C.

The 24 paintings are the work of psychiatric patients in art therapy clinics of Veterans Administration hospitals. They were chosen by James McLaughlin, curator of the Phillips Gallery in Washington. Most are of outstanding quality as art, he said.

Mostly oils and watercolors, the paintings range in subject matter from a portrait of President Eisenhower to still life of flowers and fruit, outdoor scenes, and abstractions. They were selected from VA hospitals in Montrose, N.Y., Palo Alto, Calif., Perry Point, Md., and Topeka, Kan.

\* \* \*

In May 1956 the presidents of all state psychological associations were asked to appoint a liaison representative to the American Psychological Association's committee on mental health programs to fill



out a questionnaire on the activities of psychologists in community mental health services. In states where there was no association, a leading psychologist was contacted.

Each liaison representative was asked 6 questions:

- To what extent do psychologists participate in community mental health activities?
- To what extent has the state or local psychological association evidenced interest in community mental health activities?
- To what extent is the climate of the community or state favorable or unfavorable to the participation of psychologists?
- To what extent are psychologists themselves interested in participating in community mental health problems?
- Could you list for us some examples of activity in the state involving psychologists? Could you also take note of some psychologists whom you feel are particularly active and successful in this area?
- What are your suggestions for the operation of the committee on a national scale and also on a state and local community level?

The responses concerning the degree of involvement were rated on a 5-point scale:

very extensively, extensively, moderately, poorly, hardly at all. Attitudes were rated as very favorable, favorable, neutral, unfavorable and antagonistic.

On the basis of 43 reports, Arthur J. Bindman of the Massachusetts Department of Mental Health, committee chairman, and Theodore Landsman of the University of Florida, have summarized the findings as follows:

"On a nation-wide basis, individual psychologists are involved fairly extensively in local community mental health activities. They appear to be well accepted by both lay and professional persons. In general, this type of activity is considered to be respectable.

"On the other hand, state psychologist associations show almost no interest in mental health activities in their communities. There appears to be a dichotomy between those areas where universities sponsor these interests and those where barriers of an 'ivory tower' nature intervene.

"There are also many suggestions that APA play a stronger role in interesting and influencing local and state psychological associations to take part in community health activities, as well as to publicize more widely the important role of psychologists in community mental health practice."

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